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# **Senility Before Alzheimer: Old Age in British Psychiatry, c. 1835-1912**

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## **Abbreviations**

LCC (London County Council)

MAB (Metropolitan Asylums Board)

MPA (Medico-Psychological Association)

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This thesis is dedicated to my mum, Debbie Andrews, whose determination to understand people on their own terms inspired this project. I hope some of that humanity speaks through these pages.

## Declaration

I declare that this thesis is entirely my own work, and does not contain material submitted for examination for a degree at any other university.

## Abstract

This thesis addresses the place of old age in British psychiatry, from 1835-1912. It asks: how were mental disorders in old age understood, categorised and responded to? It seeks answers to these questions in three sets of sources: theoretical published works written by professional psychiatrists, the official reports of the bodies charged with managing the asylum at a national and local level, and in the patient records of Hanwell County Lunatic Asylum.

It argues that the 'senile' became more clearly defined in the latter nineteenth century, in politics and in medicine, as a residual category of person: too insane for the workhouse, too old for the asylum. It shows that, during this period, older people in the asylum were increasingly likely to be viewed *as* 'old'. Through the increasing focus on internal pathology as an aetiological determinant of mental disorder, both engendered and reflected in changes to the asylum's patient records, the inherent agedness of older people – with associations of inevitable decline, incurability and dependency – became central to the way that psychiatrists interpreted their mental disorders.

The senile were a controversial group in nineteenth-century psychiatry. The administrators of Lunacy made attempts to exclude them from the asylum, but families and workhouse officials continued to send them there. The asylum played an important role in latter-nineteenth-century London as a pressure-valve for those whose behaviour made them unmanageable in other settings. Without more specialised provision, the asylum was often the only institution which could manage the elderly mentally disordered. Once there, aged patients worked and were cared for alongside the rest of the asylum population, usually until their death.

## Introduction

On July 19<sup>th</sup> 1900, three medical students sat down to take the examination for the Certificate in Psychological Medicine, accredited by the Medico-Psychological Association of Great Britain and Ireland (MPA). The first question on the paper asked:

What forms of insanity may occur in old age, and what is the prognosis in each? What conditions would make you recommend removal to an asylum in a case of senile dementia?<sup>1</sup>

This was really two questions, each asking the students to draw on very different areas of knowledge and experience. The first is theoretical and clinical, requiring knowledge of diagnostic nomenclature and classification. If the students had read William Bevan Lewis' *Text-book of Mental Diseases* in preparation for their exam, they would have been forewarned that, 'The student is...too apt to assume that all varieties of mental ailments in the aged issue in senile dementia'.<sup>2</sup> The question is helpfully worded to overcome that assumption, encouraging the students to take Bevan Lewis' view that the insanity of old age could manifest in a great variety of ways, with a range of outcomes. The second question is practical and political. By 1900, complaints about 'senile' asylum admissions were a regular feature in the MPA's *Journal of Mental Science*. Throughout the second half of the nineteenth century, many asylum officials were persistent in their attempts to keep such cases out of their institutions, and to delegitimise the claim that senile patients had to asylum care. At the same time, patients diagnosed with senile dementia were an inescapable fact of asylum life: no matter how much their presence was decried, new cases kept arriving. The medical assessment of senile patients, then, was a political issue: one in which the very meaning and purpose of the institution was at stake.

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<sup>1</sup> 'Notices by the Registrar', *Journal of Mental Science*, 46 (1900), p. 830.

<sup>2</sup> William Bevan Lewis, *A Text-book of Mental Diseases: with Special Reference to the Pathological Aspects of Insanity* (London, 1889), p. 405.

This thesis seeks to illuminate some of the issues the students might have addressed. It asks: how were the mental disturbances of old age understood, categorised and responded to by Victorian psychiatry? This introduction will begin by defining the object of study: old-age mental disorder. It will then discuss the locus of study: intellectual, institutional and geographical. This is followed by an outline of the two major areas of historiography from which this thesis draws – the history of the asylum and the history of old age – along with some indications of where it is situated in relation to them. Finally, an outline of the sources and approaches mobilised by each chapter is provided, along with a summary of the overall key themes and arguments.

### **Defining the Object of Study**

Defining the object of study has been one of the primary challenges of this thesis. In the 1960s, critical psychiatrists like Thomas Szasz, and historian and philosopher Michel Foucault, highlighted the instability of psychiatric categories.<sup>3</sup> They argued that psychiatric categories – indeed, the categories of madness and mental illness themselves – are inherently embedded within their social, cultural and intellectual contexts. Psychiatric categories are thus historically contingent. Retrospective diagnosis – a clinical-historical practice which takes present-day psychiatric categories and attempts to apply them to people from the past – is therefore considered by many historians of psychiatry to be epistemologically unsound.<sup>4</sup> As Sally Schwarz puts it, attempts to apply modern diagnostic categories to the past ‘presuppose and proceed to confirm, in a tautological way, the existence of

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<sup>3</sup> Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York, 1961); Michel Foucault, *Madness and Civilization: a History of Insanity in the Age of Reason* (London, 1965). Attempting to classify Foucault in relation to established academic disciplines proves challenging, as he himself acknowledged, although ‘almost all his books are at least superficially classifiable as histories’. Gary Gutting, ‘Foucault and the History of Madness’, in Gary Gutting (ed.), *The Cambridge Companion to Foucault* (Cambridge, 1994), p. 47.

<sup>4</sup> See, for example, James Mills, ‘The Mad and the Past: Retrospective Diagnosis, Post-Coloniality, Discourse Analysis and the Asylum Archive’, *Journal of Medical Humanities*, 21 (2000), pp. 141-58; Eric J. Engstrom, Wolfgang Burgmair and Matthias M. Weber, ‘Emil Kraepelin’s ‘Self-Assessment’: Clinical Autography in Historical Context’, *History of Psychiatry*, 13 (2002), p. 98. Even German Berrios, a clinical-historical practitioner whose work revolves around the examination of clinical categories, has suggested that historical diagnoses are ‘as valid’ as those drawn from current diagnostic nomenclature. G. E. Berrios, ‘Retrospective Diagnosis and its Vicissitudes’, *History of Psychiatry*, 24 (2013), p. 126.

syndromes which are argued to remain stable over time'.<sup>5</sup> A more critical approach, however, leaves historians of psychiatry to face, for themselves, 'psychiatry's knowledge problem – the elusiveness of certainty'.<sup>6</sup> They must find ways of establishing the object of their investigation, without 'presupposing' the existence of certain categorical entities.

Often, old-age dementia and Alzheimer's disease are seen as exceptions to this 'knowledge problem'. Philosopher Ian Hacking has influentially contended that new psychiatric categories (and other categories relating to types of people) do not describe pre-existent entities, but 'bring into being a new kind of person'.<sup>7</sup> Yet he classifies Alzheimer's disease, not as one of these 'human kinds', but as an unequivocally 'natural kind': 'an absolutely objective neurological condition'.<sup>8</sup> Historian of psychiatry, Mikkel Borch-Jacobsen, has criticised Hacking for not going far enough in his relativistic critique of psychiatric categories. On the first page of his book, *Making Minds and Madness*, Borsch-Jacobsen firmly denounces the historical tendency to engage in 'objectivist complicity' with present-day psychiatrists and their categories. Yet even this committed relativist makes exceptions for certain 'mental disorders with a clearly organic foundation', those which 'escape from history' by dint of their unequivocal organic basis. He names Alzheimer's disease as one such ahistorical entity.<sup>9</sup>

The twentieth-century history of Alzheimer's disease, however, shows that the ahistorical status of dementia and Alzheimer's disease is not quite as certain as Borsch-Jacobsen suggests. Alzheimer's disease was first named in 1910, but the term did not come into regular use until the mid-twentieth century. The adoption of this new category involved a re-conceptualisation of old-age dementia: from a

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<sup>5</sup> Sally Swartz, 'Changing Diagnoses in Valkenberg Asylum, Cape Colony, 1891-1920: a Longitudinal View', *History of Psychiatry*, 6 (1995), p. 451.

<sup>6</sup> Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton, 1994), p. 4.

<sup>7</sup> Ian Hacking, 'Kinds of People: Moving Targets', *Proceedings of the British Academy*, 151 (2007), p. 285; Ian Hacking, 'Making up People', in Thomas C. Heller, Morton Sosna and David E. Wellbery (eds), *Reconstructing Individualism: Autonomy, Individuality and the Self in Western Thought* (Stanford, 1986), pp. 222-36.

<sup>8</sup> Ian Hacking, 'Get Knitting', *London Review of Books*, 27 (2005), p. 20.

<sup>9</sup> Mikkel Borch-Jacobsen, *Making Minds and Madness: From Hysteria to Depression* (Cambridge, 2009), pp. 1-2.



product of the natural ageing process, to a potentially curable disease. Historians such as Jesse Ballenger and Patrick Fox, and critical dementia theorist, Thomas Kitwood, have argued that this reconceptualisation was the result of a confluence of interests between medical researchers and lay campaigners.<sup>10</sup> Simply put, it was easier to attract funding and attention for a clearly defined – potentially curable – disease category, than for a syndrome connected to the inevitable, and still largely opaque, process of old-age decline. Through this historical narrative, Alzheimer's and dementia emerge as deeply contingent categories, even if they have an 'absolutely objective neurological condition' underpinning them.

For these reasons, this thesis cannot be called a history of senile dementia, or a pre-history of Alzheimer's. Rather, it treats the categories of senility and dementia as objects of historical analysis, and draws attention to other categories which have been used to describe mental disorder in and of old age. At the same time, it is inescapably a history of the present, forged in response to the discursive, political and personal impact of the twenty-first-century 'ageing society' and the 'challenge of dementia'.<sup>11</sup> This project was undertaken in the hope that history could offer novel ways of thinking about this contemporary crisis. This thesis is therefore primarily interested in mental disorders which appeared for the first time in old age, and were linked explicitly to the ageing process. Chronic insanity and ageing *in the asylum* are mentioned only briefly in this thesis: these are large and significant topics which require dedicated studies of their own.<sup>12</sup> However, a

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<sup>10</sup> Jesse Ballenger, *Self, Senility, and Alzheimer's Disease in Modern America: a History* (Baltimore, 2006), pp. 81-112; Thomas Beach, 'The History of Alzheimer's Disease: Three Debates', *Journal of the History of Medicine and Allied Sciences*, 42 (1987), pp. 327-49; Patrick J. Fox, 'From Senility to Alzheimer's Disease: The Rise of the Alzheimer's Disease Movement', *The Milbank Quarterly*, 67 (1989), pp. 58-102; Tom Kitwood, 'Dementia: Social Section - Part II', in G. E. Berrios and Roy Porter (ed.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London, 1995), pp. 63-71.

<sup>11</sup> 'Apocalyptic demography' is a politically-charged phrase, usually used to critique the widespread notion that our society is moving towards an age-based social crisis. See Ellen M. Gee and Gloria M. Gutman, *The Overselling of Population Aging: Apocalyptic Demography, Intergenerational Challenges, and Social Policy* (Don Mills, 2000). The 'dementia challenge' is a British policy-based phrase: Department of Health, *Prime Minister's Challenge on Dementia* (26 March, 2012). This report predicts that 1.7 million people in Britain will be living with dementia by 2051.

<sup>12</sup> Vicky Long is currently undertaking work on chronic mental illness in post-war Britain, see Vicky Long, 'Rethinking Post-war Mental Health Care: Industrial Therapy and the Chronic Mental Patient in Britain', *Social History of Medicine*, 26 (2013), pp. 738-58.

complete separation between two phenomena – old age and chronicity – is neither practically possible, nor intellectually justified.

Choosing a chronological starting point for old age is not straightforward: the life course is also afflicted with a categorical ‘knowledge problem’. However, it has been necessary to set a point in order to collect a sample of patient records. Chapters Three, Four and Five are based on a sample of patient case notes from Hanwell Asylum between 1851 and 1912. All of these patients were (or were believed to be) aged 60 or over when they were admitted.<sup>13</sup> Historians of old age have emphasised that, prior to the institution of widespread retirement in the twentieth century, old age was more likely to be defined by function and capacity, and other cultural markers, than by chronology.<sup>14</sup> This being said, the use of 60 as a starting-point for old age has a long historical precedent. Historian of old age, Pat Thane, has suggested that ‘sixty was long the age at which law or custom permitted withdrawal from public activities on grounds of old age’, an inference based primarily on the exclusion of the over- 60s from a variety of legal obligations under the 1349 Ordinance of Labours.<sup>15</sup> The youngest person to be described as ‘senile’ in Hanwell’s case notes during the sample years was aged 60. Selecting patient case notes by age, rather than diagnosis, has necessarily led to some conflation of chronicity and ageing. However, widening the net to include patients who were not necessarily labelled as ‘old’ or ‘senile’, has revealed the growing importance of old age as a category in nineteenth-century psychiatry.

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<sup>13</sup> Historian James Mills is highly critical of the practice of creating age profiles from asylum case notes, noting that doctors often did not know patients’ real ages. While this may be true, it does not seriously affect the meaning of the age data collected in this study. What matters here is how the perceived old age of a patient affected the way that their mental disorder was understood, categorised and responded to, more so than the actual age of the patient. In cases where an age was entered on admission, and then an amended age given after a visit from a friend or relative, the amended age is used. When no actual age was recorded, and the age is given as – for example – ‘appears 60’, then that is the age which is used. James H. Mills, *Madness, Cannabis and Colonialism: the ‘Native-Only’ Lunatic Asylums of British India, 1857-1900* (Basingstoke, 2000), pp. 16-17.

<sup>14</sup> Janet Roebuck, ‘When Does “Old Age” Begin?: The Evolution of the English Definition’, *Journal of Social History*, 12 (1979), p. 417; Susannah R Ottaway, *The Decline of Life: Old Age in Eighteenth-Century England* (Cambridge, 2004), p. 17.

<sup>15</sup> Pat Thane, ‘Social Histories of Old Age and Aging’, *Journal of Social History*, 37 (2003), p. 97; Shulamith Shahar, ‘Old Age in the High and Late Middle Ages’, in Paul Johnson and Pat Thane (eds), *Old Age from Antiquity to Post-Modernity* (London, 1998), p. 43.

## Defining the Locus of Study

This thesis examines responses to, and understandings of, old-age mental disorder, from a particular perspective: that of psychiatry. Psychiatry in itself is an anachronistic term, which did not come into common usage until the 1890s. As historian Janet Oppenheim has pointed out, echoed by literary scholar Helen Small, 'nomenclature for the medical doctor who tended to the insane was revised and re-revised in the Victorian period'.<sup>16</sup> Some historians have chosen 'alienist' or 'medico-psychologist' as their preferred term to refer to medical specialists in mental illness, in an attempt to preserve historical accuracy.<sup>17</sup> This study follows Helen Small in adopting the anachronistic term 'psychiatrist', for the sake of simplicity, underscored with a clear definition. Psychiatry in nineteenth-century Britain can be defined intellectually and institutionally. Historian Ludwig Fleck's concept of a 'thought collective' – 'a community of persons mutually exchanging ideas or maintaining intellectual interaction' – is useful here.<sup>18</sup> The thought community, of what this thesis will call 'psychiatrists', interacted regularly through the pages of the *Journal of Mental Science*, and through the meetings of the MPA. Some of them published textbooks and treatises, in which they referred to and refined each other's work. In these texts, they produced a body of knowledge with a shared referent: the insane person.

As well as interacting through these shared forums, almost all of the psychiatrists who published in the *Journal of Mental Science* shared a common profession: Medical Superintendent of a lunatic asylum. This thesis will refer to all asylum medical officers, who were professionally engaged in the care and treatment of the insane, as 'psychiatrists', even if they did not actively participate in the production of published psychiatric knowledge. The asylum provided the locus for

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<sup>16</sup> Janet Oppenheim, *Shattered Nerves: Doctors, Patients, and Depression in Victorian England* (New York, 1991), p. 27, as referenced in Helen Small, 'In the Guise of Science': Literature and the Rhetoric of Nineteenth-Century English Psychiatry', *History of the Human Sciences*, 7 (1994), p. 32.

<sup>17</sup> Gayle Davis, *The Cruel Madness of Love: Sex, Syphilis and Psychiatry in Scotland, 1880-1930* (Amsterdam, 2008), p. 15; Michael Anthony Finn, 'The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century', (PhD Thesis, University of Leeds, 2012), p. 46.

<sup>18</sup> Ludwik Fleck, *Genesis and Development of a Scientific Fact* (Chicago, 1979), p. 39.

the development of psychiatry as a medical specialism in the eighteenth and nineteenth centuries, and provides the institutional context for this thesis.<sup>19</sup> Nineteenth-century psychiatry was dominated by large pauper county lunatic asylums, funded by local rates, mostly accommodating those who could not afford to contribute to their own care.<sup>20</sup> In 1808, the County Asylums Act empowered local Justices of the Peace to build asylums for the care and treatment of their pauper lunatics. It was under this act that the institutional case study of this thesis – Hanwell Asylum in North-West London – was built. In 1845, the County Asylums Act made this provision compulsory. By 1854 there were 37 county lunatic asylums in England, rising to 63 in 1884, and reaching 97 in 1914.<sup>21</sup>

There are two main reasons for limiting this study largely to the theory and institutions of psychiatry. Firstly, the focus on psychiatry is a product of the present-centric starting point of the project. Dementia, a category which remains current in the description and classification of old-age mental disorders in the twenty-first century, was a central category in nineteenth-century psychiatry, and was used to describe much more than just old-age mental disorders.<sup>22</sup> In order to

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<sup>19</sup> Roy Porter, *Mind-Forg'd Manacles: a History of Madness in England from the Restoration to the Regency* (London, 1987), p. 167; Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (New Haven, 1993), pp. 232-51.

<sup>20</sup> The institutional care of the insane has a long history, particularly in London, where the infamous Bethlem hospital provided specialised care to the insane since at least the fifteenth century. The eighteenth century saw the proliferation of private madhouses, run by savvy medical entrepreneurs. Private and charitable institutions for the insane continued to exist in the nineteenth century, taking in very wealthy patients (such as Ticehurst Asylum in Sussex), the respectable, but not wealthy, middle-classes (such as Holloway Sanatorium in Surrey), or paupers whose Poor Law Unions were unable to accommodate them (such as the Bethnal Green Asylum in East London). On Bethlem, see Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker and Keir Waddington, *The History of Bethlem* (London, 1997). On eighteenth-century madhouses, see Porter, *Mind-Forg'd Manacles*, pp. 110-68; William Parry-Jones, *The Trade in Lunacy: a Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London, 1972). On private and charitable institutions in the nineteenth century, see Charlotte MacKenzie, *Psychiatry for the Rich: a History of Ticehurst Private Asylum, 1792-1917* (London, 1992); Anne Shepherd, 'Mental health Care and Charity for the Middling Sort: Holloway Sanatorium 1885-1900', in Anne Borsay and Peter Shapely (ed.), *Medicine, Charity and Mutual Aid the Consumption of Health and Welfare in Britain, c.1550-1950* (Aldershot, 2007), pp. 163-82; Elaine Murphy, 'A Mad House Transformed: The Lives and Work of Charles James Beverley FRS (1788-1868) and John Warburton FRS (1795-1847)', *Notes and Records*, 58 (2004), pp. 267-81.

<sup>21</sup> Scull, *Most Solitary of Afflictions*, p. 369.

<sup>22</sup> Having said this, dementia was controversially removed from the new edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Due apparently to the stigma attached to the term, it was replaced with 'mild' and 'major neurocognitive disorder', provoking much discussion about the creeping pathologisation of 'normal' old age: S. Katz

fully understand the meaning of this term in the nineteenth century, it must be placed within the context of psychiatry as a whole. The second reason is the richness and availability of the asylum records. Nineteenth-century asylum doctors and administrators prolifically produced material – printed and hand-written – relating to the management, treatment and care of its population<sup>23</sup> Asylum case notes in particular are unparalleled in the depth of information they provide about the lives, and treatment, of ordinary mentally-disordered people. Of course, not every person who suffered from old-age mental disorder entered an asylum, and not everyone who wrote about it did so from the perspective of psychiatry. The focus on a county lunatic asylum also limits this thesis to an examination of old-age mental disorder among poorer people. Alternative provision for the care of the aged mentally disordered with greater financial means – in private homes, private asylums, or through the employment of servant-carers – are not discussed. This thesis, then, provides only a partial view of old-age mental disorder in the nineteenth-century, the implications of which are discussed in the conclusion.

As well as being limited to psychiatry, this study is limited geographically – to London. Nineteenth-century London was, above all else, populous. Between 1800 and 1910, the city experienced a population explosion, going from just under 1 million inhabitants, to 4.5 million (over 7 million if the increasing suburban sprawl of Greater London is taken into account), making it by far the largest city in the world.<sup>24</sup> This population was characterised by high numbers of migrants – the net population gain in London through migration between 1841 and 1911 was 1.25 million – and by a comparative youthfulness wrought by this migrant population: with a larger proportion of 15-34-year-olds than elsewhere in England and Wales,

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and K. R. Peters, 'Enhancing the Mind? Memory Medicine, Dementia, and the Aging Brain', *Journal of Aging Studies*, 22 (2008), pp. 348-55; Daniel R. George, Peter J. Whitehouse and Jesse Ballenger, 'The Evolving Classification of Dementia: Placing the DSM-V in a Meaningful Historical and Cultural Context and Pondering the Future of "Alzheimer's"', *Culture, Medicine, and Psychiatry*, 35 (2011), pp. 426-30; Tiago Moreira, Carl May and John Bond, 'Regulatory Objectivity in Action: Mild Cognitive Impairment and the Collective Production of Uncertainty', *Social Studies of Science*, 39 (2009), pp. 665-90.

<sup>23</sup> Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11 (1998), pp. 255-56.

<sup>24</sup> Michael Ball and David Sunderland, *An Economic History of London, 1800-1914* (London, 2001), p. 42.

and a smaller proportion of over 55s.<sup>25</sup> It was also characterised, in the contemporary mind, by poverty: a dangerous, unknown anarchistic type of poverty, engendered by a casually (un)employed and highly mobile population.<sup>26</sup> More recent historical investigations have questioned the extent to which London was genuinely beset by disproportionate levels of poverty.<sup>27</sup> There was, however, an unquestionably high level of pauperism.<sup>28</sup> In 1870, London contained 15 per cent of the paupers in England and Wales which, although proportionate to the relative size of its population, was particularly visible in the concentrated urban space.<sup>29</sup> The visibility of pauperism in London was enhanced by the tendency of London Poor Law Unions to administer relief via the workhouse, rather than through out-relief payments: by the early 1890s, 82 per cent of London's paupers were relieved in the workhouse, compared with 34 per cent in the rest of England.<sup>30</sup> This enormous workhouse population was not made up of the feckless, young, migrant poor, but by the aged: in the second half of the nineteenth century, half of London's workhouse inmates were aged 60 or over.<sup>31</sup> There may have been fewer over 55s in London than in the rest of the country, then, but aged paupers were highly visible in London, and a major part of the problem with which London's Poor Law Guardians had to contend.

London's unique characteristics – its size, its wealth disparity, its large and diverse institutionalised population – led to certain innovations in social policy, and make it a particularly interesting place to study responses to old age mental disorder. In 1867, the Metropolitan Poor Act established a new administrative body – the Metropolitan Asylums Board (MAB) – which was empowered to build specialised medical institutions for London's paupers, funded by a rate levied on

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<sup>25</sup> Ball and Sunderland, *An Economic History of London*, pp. 44, 49.

<sup>26</sup> Gareth Stedman Jones, *Outcast London: a Study in the Relationship Between Classes in Victorian Society* (Oxford, 1971).

<sup>27</sup> Ball and Sunderland, *An Economic History of London*, p. 111.

<sup>28</sup> The number of people who received relief through the Poor Law.

<sup>29</sup> David R. Green, *Pauper Capital: London and the Poor Law, 1790-1870* (Farnham, 2010), p. 191

<sup>30</sup> George R. Boyer and Timothy P. Schmidle, 'Poverty Among the Elderly in Late Victorian England', *The Economic History Review*, 62 (2009), p. 262.

<sup>31</sup> Lynn Hollen Lees, 'The Survival of the Unfit: Welfare Policies and Family Maintenance in Nineteenth-Century London', in Peter Mandler (ed.), *The Uses of Charity: The Poor on Relief in the Nineteenth-Century Metropolis* (Philadelphia, 1990), p. 76.

each London Poor Law Union, with the amount contributed dependent on their income.<sup>32</sup> By 1877, the MAB had opened five 'isolation hospitals' for fever and smallpox sufferers, and two 'imbecile asylums', at Caterham and Leavesden. The MAB imbecile asylums were designed to cater for an ambiguously defined cohort of chronic and incurable lunatics and the mentally infirm. They were technically workhouses – funded by the local rates and overseen by the Local Government Board (the central body which oversaw the administration of the Poor Law) – but entering them required a form of certification. They thus occupied an intermediate space between the workhouse and the asylum. Their ambiguous status made Leavesden and Caterham ideal institutions to deal with the similarly ambiguous senile population, but the MAB managers fiercely resisted this role. The second chapter of this thesis examines the response of the MAB to aged patients, as an illustrative case study of the pervasive inertia and resistance of Victorian welfare providers in the face of an elderly mentally-disordered population.

The major case study of this thesis is, however, the 1<sup>st</sup> Middlesex County Asylum at Hanwell (known simply as 'Hanwell Asylum' after 1889).<sup>33</sup> Hanwell opened in 1831, and was the oldest – and, for much of the century, the largest – of London's county asylums. In the 1840s, Hanwell came to embody the early optimism of the asylums project, following the pioneering implementation of a policy of non-restraint. After joining Hanwell as Medical Superintendent in 1839, Dr John Conolly renounced the use of physical coercion to control violent or unruly inmates.<sup>34</sup> Conolly focussed on maintaining an efficient and impersonal orderly regime, with clear rules and disciplined attendants, operating within pleasant

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<sup>32</sup> Gwendoline M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board, 1867-1930* (London, 1971); Green, *Pauper Capital*, pp. 235-45.

<sup>33</sup> Middlesex was the old county which comprised of most of what would now be considered London north of the Thames, as far east as Tottenham and Edmonton, as well as rural areas to the north and west. After the 1889 Local Government Act, most of this was incorporated into the new county of London, and Hanwell came under the control of the London County Council.

<sup>34</sup> Andrew Scull, 'John Conolly: a Victorian Psychiatric Career', in Andrew Scull (ed.), *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (London, 1989), pp. 162-213; Nancy Tomes, 'The Great Restraint Controversy: a Comparative Perspective on Anglo-American Psychiatry in the Nineteenth Century', in William F. Bynum and Roy Porter (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. III* (London, 1988), pp. 190-225; Akihito Suzuki, 'The Politics and Ideology of Non-Restraint: The Case of Hanwell Asylum', *Medical History* 39 (1995), pp. 1-17.

domestic surroundings.<sup>35</sup> While the move towards non-restraint was initially controversial in medical circles, *The Times* lauded Conolly as a hero and, in 1842, the Duke of Cambridge declared Hanwell an 'admirable institution'.<sup>36</sup>

However, the glory days of Hanwell were short-lived. The number of resident patients quickly outstripped the available resources, reaching 1,000 in 1854. In 1856, four years after Conolly had left the asylum following a protracted period of disagreement with the managing Justices, a writer in the *Journal of Mental Science* declared that

for our own honour it is necessary that [our fellow  
psychologists abroad] should know that the glory of Hanwell is  
passed away; that it is a very inferior and in many respects an  
ill-built, ill-adapted, and an indifferently managed asylum.<sup>37</sup>

Hanwell's reputation never recovered. The asylum continued to grow, reaching 1,500 patients in 1862. In 1871, psychiatrist William Lauder Lindsay described it as a 'monster' asylum.<sup>38</sup> In 1875, as part of a large-scale investigation of the state of provision for lunatics in the south of England undertaken for *The Lancet*, J. Mortimer Granville was damning of any pretensions Hanwell might have to the status of a curative or medical institution: '[Although] it may be available as a place of refuge for imbecile and chronic cases of mental disease...the notion of sending there acute or recent, and therefore possibly curable cases, should be wholly and at once abandoned'.<sup>39</sup> It is perhaps no coincidence that one Hanwell Superintendent from the 1870s and 80s, Henry Rayner, went on to become a champion of out-patient

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<sup>35</sup> Suzuki, 'The Politics and Ideology of Non-Restraint', pp. 15-16.

<sup>36</sup> Scull, 'John Conolly', pp. 189-92; *The Times*, 8 March 1842, p. 13, as quoted in Scull, 'John Conolly', p. 191.

<sup>37</sup> Scull, 'John Conolly', pp. 197-200; Suzuki, 'The Politics and Ideology of Non-Restraint', pp. 16-17; J. T. A., 'The Middlesex County Lunatic Asylums, and their Reports for 1855 and 1856', *Journal of Mental Science*, 2 (1856), p. 355.

<sup>38</sup> W. Lauder Lindsay, 'The Family System as Applied to the Treatment of the Chronic Insane', *Journal of Mental Science*, 16 (1871), p. 517.

<sup>39</sup> J. Mortimer Granville, 'Report of The Lancet Commission on Lunatic Asylums', *The Lancet*, 106 (1875), p. 890.



mental health care.<sup>40</sup> During the mid-nineteenth century, Hanwell had transformed from the embodiment of the hopes of the asylums project, to an indictment of its failings.

By the turn of the century, when Hanwell reached its sixtieth year, it had long since entered its senility: crumbling, pitied and apparently irredeemable. In 1910, the spring meeting of the South-Eastern division of the MPA was held at Hanwell. Long-standing Medical Superintendent, Percy J. Baily, chose to give an address on the topic of the asylum's history, rather than on any new developments in asylum practice.<sup>41</sup> Like the stereotypical old man who 'shrinks from new enterprises' and 'lauds the past, concerning which he has the memories of interest and policies and achievements', Baily's choice to focus on Hanwell's long-past glories was an (unintentional) indictment of the stagnation which had occurred in the intervening decades.<sup>42</sup> Hanwell's latter-nineteenth-century incarnation as the old man of English asylumdom, its worldly achievements well behind it, makes it a particularly interesting place to study the aged and old age. On one hand, Hanwell keenly felt the pressures of institutional overcrowding, and as such had every reason to protest against the admission of 'undesirable cases'. On the other hand, by the 1870s, the reputation of Hanwell as a receptacle for the incurable was assured, and its doctors and managers were forced to come to terms with their role as providers of care for the elderly mentally disordered and other unpromising patients. Hanwell's patient records suggest that, on an individual level, Hanwell's medical officers were prepared to offer the best care they could to the older patients they were confronted with.

## The History of the Asylum

The nineteenth-century asylum is already served by a rich historiography, which will be surveyed here. The historiography of the asylum in Britain is often divided

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<sup>40</sup> R. Percy Smith, 'Henry Rayner, M.D.Aberd., M.R.C.P.Edin', *Journal of Mental Science*, 72 (1926), pp. 176-77; Henry Rayner, 'Mental After-Care', *Journal of Mental Science*, 70 (1924), pp. 358-62.

<sup>41</sup> 'Medico-Psychological Association. South-Eastern Division', *Journal of Mental Science*, 56 (1910), pp. 558-68.

<sup>42</sup> This description of old age was written by psychiatrist Henry Maudsley: Henry Maudsley, *The Physiology of Mind* (London, 1879), p. 537.

into three phases, characterised as 'traditional', 'revisionist' and 'counter-revisionist'.<sup>43</sup> The oppositional claims of these historiographic approaches, and the debates they have engendered, have set the research agenda for most British asylum histories. The first phase in the history of psychiatry was written by psychiatrists, seeking to account for the development of their own profession. Secure in their belief that 'history is made by men', the accounts produced by these clinician-historians were conservative and hagiographic.<sup>44</sup> Kathleen Jones' pioneering 1955 text *Lunacy, Law and Conscience*, and its successor *Mental Health and Social Policy*, are anomalies amongst these early works.<sup>45</sup> Jones' area of specialism was social policy, rather than psychiatry, and her books constituted the first systematic examination of the lunacy reforms of the nineteenth century. Ultimately, however, her work sits neatly alongside that of the clinician-historians: telling a narrative of benevolent progress, in which psychiatrists were thwarted in their attempt to offer humane and effective treatments by the unnecessary interference of the legal profession.<sup>46</sup> Although superseded by revisionist approaches, this clinically-oriented approach to the history of the asylum has not disappeared. Edward Shorter's *A History of Psychiatry*, for example, sought to 'rescue the history of psychiatry from the sectarians who have made the subject a sandbox for their ideologies', by presenting an account of the shifting dominance of different interpretations of the mind-body problem in nineteenth- and twentieth-century psychiatry.<sup>47</sup> Psychiatrist-historians continue to publish clinically-oriented historical studies, seeking to apply

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<sup>43</sup> See, for example, Roy Porter, 'History of Psychiatry in Britain', *History of Psychiatry*, 2 (1991), pp. 271-79; T. E. Brown, 'Dance of the Dialectic? Some Reflections (Polemic and Otherwise) on the Present State of Nineteenth-Century Asylum Studies', *Canadian Bulletin of Medical History*, 11 (1994), pp. 267-90.

<sup>44</sup> Denis Leigh, *The Historical Development of British Psychiatry* (Oxford, 1961); Franz Alexander and Sheldon T. Selesnick, *The History of Psychiatry: an Evaluation of Psychiatric Thought and Practice from Prehistoric Times to the Present* (New York, 1968), p. i.

<sup>45</sup> Kathleen Jones, *Lunacy, Law and Conscience, 1744-1845: the Social History of Care of the Insane* (London, 1955); Kathleen Jones, *Mental Health and Social Policy, 1845-1959* (London, 1960)

<sup>46</sup> Jones, *Mental Health and Social Policy*, pp. 7-40.

<sup>47</sup> Edward Shorter, *A History of Psychiatry: from the Era of the Asylum to the Age of Prozac* (New York, 1997), p. viii.

retrospective diagnoses to asylum records; indeed, the only existent study of old age in an English asylum takes this approach.<sup>48</sup>

As early as the 1960s, however, the narrative of benevolent scientific progress – along with psychiatry itself – was being challenged on a number of fronts. In 1960, two young psychiatrists published works which began long careers of challenging the very existence of mental illnesses as imagined by the medical discipline of psychiatry: Thomas Szasz argued in 'The Myth of Mental Illness' that the phenomena we call 'mental illnesses' are not, in fact, ontological entities, but a mythical construct which attempt to capture multifaceted "problems in living"; while R.D. Laing's *The Divided Self* suggested that schizophrenia was not an organic entity, but a response to the existential problems of maintaining an authentic self.<sup>49</sup> These direct challenges to the legitimacy of psychiatric knowledge significantly undermined clinician-historians' attempts to chart its teleological development. A year later, American sociologist Erving Goffman published *Asylums*, a study which challenged the benevolence and effectiveness of institutional psychiatric treatment, arguing that the asylum was a 'total institution' which removed inmates' personal agency, rendering them docile and passive, rather than 'cured'.<sup>50</sup>

Michel Foucault's 1964 *Histoire de la Folie*, an abridged version of his 1961 doctoral dissertation, applied this critical stance to psychiatry and its institutions directly to their history. Published in an English translation in 1965 – in a series edited by R.D. Laing – *Madness and Civilization* examined attitudes and understandings of madness across a broad sweep of European history, from the Middle Ages to the beginning of the twentieth century. It is rich with insights, but perhaps the most influential is its elucidation of the interrelationship between the act of institutionalisation, the emergence of the psychiatric profession, and the conceptualisation of madness. The modern understanding of madness, Foucault

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<sup>48</sup> Graeme Yorston and Camilla Haw, 'Old and Mad in Victorian Oxford: a Study of Patients Aged 60 and Over Admitted to the Warneford and Littlemore Asylums in the Nineteenth Century', *History of Psychiatry*, 16 (2005), pp. 395-421.

<sup>49</sup> Thomas Szasz, 'The Myth of Mental Illness', *The American Psychologist*, 16 (1960), pp. 113-18; R.D. Laing, *The Divided Self: A Study in Sanity and Madness* (London, 1960).

<sup>50</sup> Erving Goffman, *Asylums; Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, 1961).

argued, was a product of the Enlightenment: a form of unreason, created in opposition to the new ruling value of reason.<sup>51</sup> The division of unreason from reason ushered in a 'Great Confinement' of the unreasonable in the eighteenth century, in which all those who did not follow the path of ordered, rational bourgeois productivity - the sick, the vagrant, the otherwise deviant - were segregated and confined.<sup>52</sup> From the 'depths of confinement' a new classification emerged at the beginning of the nineteenth century: madness was split off decisively from other forms of unreason, into a dedicated institution - the asylum - where the medical model of mental illness reigned. Madness came to be seen as a pathology which could and should be recovered from, and psychiatry emerged as the autonomous profession which promised to restore the unreasonable mad back to productive reason.<sup>53</sup> Psychiatry, then, was not a response to the problem of mental illness, but was constitutive of the problem itself.<sup>54</sup>

*Madness and Civilization*, though widely criticised for its lack of empirical rigour, was the seminal work of the 'revisionist' historiography of psychiatry and the asylum which emerged in the wake of these challenges to a teleological history of psychiatry in the 1970s and 80s.<sup>55</sup> For the first time, the history of the asylum was being seriously investigated by professional historians (and sociologists), rather than clinicians, and thus a new narrative emerged which set the rise of the asylum in the context of the broad social, economic and political changes wrought by modernity. Historians such as David Rothman, Klaus Doerner and David Mellett re-interpreted nineteenth-century lunacy reforms as an attempt to remove or confine deviant sections of the population, the restore them to productive work, and

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<sup>51</sup> Foucault, *Madness and Civilization*, pp. 82-84.

<sup>52</sup> *Ibid.*, pp. 38-64.

<sup>53</sup> *Ibid.*, pp. 221-278, particularly pp. 224, 269-76, 246-7.

<sup>54</sup> Nikolas Rose emphasises this point in 'Of Madness Itself: Histoire de la Folie and the Object of Psychiatric History', in Arthur Still and Irving Velody (eds), *Rewriting the History of Madness: Studies in Foucault's Histoire de la Folie* (London, 1992); 142-149.

<sup>55</sup> For more on the influence and criticism of Foucault's work on the history of madness, see the articles in Still and Velody (eds), *Rewriting the History of Madness*; Gutting, 'Foucault and the History of Madness'; Joseph Melling, 'Accommodating Madness: New Research in the History of Insanity and Institutions', in Joseph Melling and Bill Forsythe (eds), *Insanity, Institutions, and Society, 1800-1914* (London, 1999), pp. 1-3.

to shore up the social order of industrial capitalism.<sup>56</sup> While differing in emphasis, the revisionists were united in their sceptical attitudes towards the claims of psychiatrists, and their triumphant narrative of the discipline's development.

Over the last forty years, American sociologist Andrew Scull has emerged as the most prominent and tenacious of the revisionist asylum historians. In his 1979 book *Museums of Madness*, updated and revised in 1993 as *The Most Solitary of Afflictions*, Scull sought to account for the establishment and proliferation of institutions for the mad in nineteenth-century Britain, and the subsequent progressive increase in the number of incarcerated lunatics.<sup>57</sup> In the early-nineteenth century, he argues, the transition to a free-market economic system – in which poorer people gained their sustenance through wage-labour rather than through more localised systems of obligation – made a 'family-based system of caring for the insane' particularly difficult to sustain.<sup>58</sup> These same structural changes, which saw the socially undesirable underclass emerge as a simultaneously dislocated and lumpen mass, encouraged the building of 'institutions' – workhouses, prisons, asylums – as the most 'efficient and economical' means to deal with a variety of social ills.<sup>59</sup> The insane emerged from these institutional populations as a particularly problematic category of social deviant.<sup>60</sup> An entrepreneurial cadre of medical professionals seized on the opportunity afforded by this newly visible institutional population, using it as the basis for 'the

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<sup>56</sup>In *Bürger und Irre* (translated as *Madmen and the Bourgeoisie*), Doerner set the development of institutional psychiatry across Britain, France and Germany in the context of 'the political and industrial-capitalist bourgeois social revolution', framing it as a product of Enlightenment ideology and nineteenth century 'class struggle'. Rothman offered a more parochial interpretation of *The Discovery of the Asylum* in early-nineteenth-century America, as an attempt to shore up social cohesion and harmony in the face of the significant social and political uncertainty facing the new republic. Mellett, focussing on the asylum in Britain, argued that it operated as a 'convenient tactic of social control' over a growing, and increasingly urbanised, population. Klaus Doerner (trans. Joachim Neugroschel and Jean Steinberg), *Madmen and the Bourgeoisie: A Social History of Insanity and Psychiatry* (Oxford, 1981), p. 1; David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston, 1971), pp. xviii-xix; D. J. Mellett, *The Prerogative of Asylums: Social, Cultural, and Administrative Aspects of the Institutional Treatment of the Insane in Nineteenth-Century Britain* (New York, 1982), pp. 14-21.

<sup>57</sup> Andrew Scull, *Museums of Madness: the Social Organization of Insanity in Nineteenth-Century England* (New York, 1979); Scull, *Most Solitary of Afflictions*.

<sup>58</sup> Scull, *Most Solitary of Afflictions*, pp. 31-33.

<sup>59</sup> *Ibid.*, pp. 33-34.

<sup>60</sup> *Ibid.*, pp. 34-40.

establishment of a new organised profession': psychiatry. Through their efforts, in the early nineteenth century, committal to a medically-controlled lunatic asylum was reified as the only legitimate response to mental abnormality.<sup>61</sup>

Scull's grand narrative has come in for significant criticism: most convincingly, on the grounds that his chronology relies on an out-dated narrative of modernity, and an overly simplistic view of the relationship between economic and social change.<sup>62</sup> He has been charged with ignoring the complex array of strategies of care which continued to be employed alongside the county asylum, particularly in Scotland.<sup>63</sup> Nevertheless, Scull's account offers several profound insights which remain useful. One of the most interesting elements of his narrative is the way in which he ties together the activities of families who chose to institutionalise their loved ones, and those of the professionals who administered and promoted the asylum as the ideal response to insanity. Scull has been justly criticised for over-estimating the level of control held by asylum physicians in the admission of individual patients to the asylum.<sup>64</sup> However, he is also more broadly interested in the role of both families and psychiatrists in negotiating the meaning of insanity, and in creating the conditions in which asylum admission came to be seen as an acceptable response to the problem of mental disorder. He argues that, even though the proliferation of the asylum and the rise of psychiatry went a long way towards defining insanity, the precise location of the line between madness and sanity remained ambiguous. Faced with an ambiguous target population, and with an eye to their own professional security, the original lunacy reformers adopted a stance of 'incorporation rather than exclusion'.<sup>65</sup> At the same time, the emergence of the asylum, as a legitimate alternative to struggling at home with an 'intolerable member', by its very existence, encouraged families to make use of it. Thus

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<sup>61</sup> Ibid., pp. 40-45.

<sup>62</sup> Grob, G.N., 'Marxian Analysis and Mental Illness', *History of Psychiatry*, 1 (1990), pp. 223-32

<sup>63</sup> Jonathan Andrews, 'Raising the Tone of Asylumdom': Maintaining and Expelling Pauper Lunatics at the Glasgow Royal Asylum in the Nineteenth Century', in Melling and Forsythe (eds.), *Insanity, Institutions and Society*, pp. 200-1; Murphy, Elaine, 'The Lunacy Commissioners and the East London Guardians, 1845-1867', *Medical History*, 46 (2002), p. 1.

<sup>64</sup> Murphy, 'The Lunacy Commissioners and the East London Guardians, 1845-1867', p. 495; Peter Bartlett, *The Poor Law of Lunacy: the Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London, 1999), p. 22.

<sup>65</sup> Scull, *Most Solitary of Afflictions*, p. 350.

by offering another means of coping, [the emergence of the asylum] affect[ed] the degree to which people [were] prepared to put up with those who persistently create[d] havoc, discord, and disarray, as well as with those whose extreme helplessness and dependency creates extraordinary burdens for others.<sup>66</sup>

In this way, families were themselves complicit in advancing an inclusive definition of insanity.

The second and third chapters of this thesis will build on and extend this argument, although it will place greater emphasis on the role of Poor Law officials, who are marginal in Scull's account.<sup>67</sup> The admission of the elderly disordered poor to the asylum was, it argues, a manifestation and consequence of the inclusiveness of the asylum, which was recognised and used as the legitimate site for the care and containment of people whose behaviours had rendered them unmanageable anywhere else. At the same time, the pressures wrought by the increase in insanity encouraged the administrators of lunacy to advance a more *exclusive* definition of insanity, in which the manageability, incurability, and the supposed 'naturalness' of old-age mental disorder became grounds on which to contest their claim to asylum care.

Scull's emergence as the only enduringly influential of the revisionist asylum historians (apart, of course, from Foucault), was partly due to his committed involvement in the debates which his critical stance engendered.<sup>68</sup> However, the polarising nature of these debates prompted their own revisionist backlash, which saw Scull transformed from 'enfant terrible...[to an] orthodox authority and Aunt Sally figure against which a new generation of scholars seeks to prove its mettle'.<sup>69</sup>

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<sup>66</sup> Ibid., pp. 352-53.

<sup>67</sup> Drawing on the work of Bartlett, *The Poor Law of Lunacy*.

<sup>68</sup> See, for example, Andrew Scull, 'Was Insanity Increasing? A Response to Edward Hare', *The British Journal of Psychiatry*, 144 (1984), pp. 432-36; Andrew Scull, 'Psychiatrists and Historical 'Facts'. Part One: The Historiography of Somatic Treatments', *History of Psychiatry*, 6 (1995), pp. 225-41; Andrew Scull, 'Psychiatrists and Historical 'Facts' Part Two: Re-writing the History of Asylumdom', *History of Psychiatry*, 6 (1995), pp. 387-94.

<sup>69</sup> Andrew Scull, 'Rethinking the History of Asylumdom', in Melling and Forsythe (eds), *Insanity, Institutions and Society*, p. 295.

In the 1980s and 90s, a new wave of asylum historians turned towards the sources, adopting an empiricist stance which implicitly or explicitly criticised the 'overly ideologised and unconvincingly theorised' approach of revisionist historiography.<sup>70</sup> One of the most active proponents of this counter-revisionist approach, Joseph Melling, has described his peers' approach as 'sceptical' and 'cautious', rejecting 'ambitious model[s] of institutional transformation', and emphasising micropolitics, discontinuities and the local.<sup>71</sup> Detailed institutional case studies form the backbone of this historiographic approach.<sup>72</sup> While revisionist asylum historians tended to highlight the needs and interests of the political and economic elites in the creation and maintenance of the asylum, counter-revisionists have emphasised the social utility of the asylum 'from below'. By examining in more detail the precise mechanisms through which asylum patients were certified and admitted, counter-revisionist historians have shown that figures outside the asylum – the doctors and Justices who authorised the certificate, and the Poor Law officials and families who arranged this certification – were by far the most important figures in determining who was admitted to the asylum.<sup>73</sup> The implications and insights of this approach are discussed in more detail in Chapter Three.

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<sup>70</sup> Jonathan Andrews and Anne Digby, 'Gender and Class in the Historiography of British and Irish Psychiatry', in Jonathan Andrews and Anne Digby (eds), *Sex and Seclusion, Class and Custody: Perspective on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam, 2004), p. 13.

<sup>71</sup> Melling, 'Accommodating Madness' pp. 8, 11, 14, 19.

<sup>72</sup> Though very different in emphasis, these studies share a common dedication to setting the institutions within their immediate social context through detailed empirical study, and to uncovering some aspect of patients' everyday lives through the asylum records. Anne Digby, *Madness, Morality and Medicine: a Study of the York Retreat, 1796-1914* (Cambridge, 1985); J. L. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum--St. John's* (London, 1990); Joseph Melling and Bill Forsythe, *The Politics of Madness: the State, Insanity and Society in England, 1845-1914* (London, 2006). Other English examples include Stephen Cherry, *Mental Health Care in Modern England: the Norfolk Lunatic Asylum/St. Andrew's Hospital c.1810-1998* (Suffolk, 2003) and Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000* (Cardiff, 2003). Charlotte MacKenzie has adopted the same approach in the study of the private Ticehurst asylum: MacKenzie, *Psychiatry for the Rich*. Ellen Dwyer's study of two New York asylums also provides an early example of work in this vein: Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick, 1987).

<sup>73</sup> See, for example, Bartlett, *The Poor Law of Lunacy*; David Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine*, 10 (1997) pp. 137-55.



Counter-revisionist histories of the asylum have been criticised for neglecting the importance of unequal power-relations in the asylum.<sup>74</sup> This challenge has been answered, in part, by histories of the asylum which look at the influence of class, race and gender on psychiatric discourses and practices. In the 1970s and 80s the same broad political impulses which gave rise to the revisionist critique of psychiatry and the asylum, also gave rise to feminist critiques.<sup>75</sup> Phyllis Chesler and Elaine Showalter elucidated the essentially patriarchal nature of nineteenth- and twentieth-century psychiatry, arguing that it operated as a tool to repress socially aberrant female behaviour. They argued that modern madness constituted a *Female Malady*, disproportionately experienced by, and associated with, women.<sup>76</sup> A 'nuanced' corrective to this critique has appeared in the last 15 years, as part of the broader counter-revisionist movement.<sup>77</sup> David Wright, for example, has suggested that the gendered element of the behavioural changes which often preceeded institutionalisation, was merely a reflection of the habitual influence of gender roles in daily life.<sup>78</sup> The new feminist historiography of the asylum, then, rejects the notion of the asylum as a site of female incarceration, but continues to build on the more general insight of the original feminist historiography, that madness was defined in part as a violation of gender norms. Catharine Coleborne, for example, has argued that nineteenth-century psychiatry '[articulated] the meanings of sex difference...in ways that produced the patient as either male or female'.<sup>79</sup>

In this thesis, gender is marginalised as a category of analysis, in favour of age. This is partly in response to the de-gendering effect of age reflected in the

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<sup>74</sup> Brown, 'Dance of the Dialectic', pp. 275-58.

<sup>75</sup> Nancy Tomes, 'Feminist Histories of Psychiatry', in Mark S. Micale and Roy Porter (eds), *Discovering the History of Psychiatry* (Oxford, 1994), pp. 353-58.

<sup>76</sup> Phyllis Chesler, *Women and Madness* (Garden City, 1972); Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (New York, 1985).

<sup>77</sup> Andrews and Digby, 'Gender and Class in the Historiography of British and Irish Psychiatry', pp. 8-13.

<sup>78</sup> David Wright, 'Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England', in Andrews and Digby (eds) *Sex and Seclusion, Class and Custody*, pp. 149-176.

<sup>79</sup> Catharine Coleborne, *Reading 'Madness': Gender and Difference in the Colonial Asylum in Victoria, Australia, 1848-1888* (Perth, 2007), p. 165. See also the other contributions to Andrews and Digby (eds), *Sex and Seclusion* and Louise Hide, *Gender and Class in English Asylums, 1890-1914* (Houndmills, Forthcoming 2014).

sources, as discussed in Chapter One. The case notes of Hanwell reveal a certain level of gendered differentiation in the experience of old-age mental disorder – particularly with regards to spousal relationships – but not as much as one might expect. There is, however, more to be said about the intersection between age and gender in nineteenth-century psychiatry than this thesis has found space to relate, and it is a topic in need of further study.

In recent years, gerontologists have worked to establish ‘age’ as a major category of social analysis alongside class, race and gender.<sup>80</sup> Old age has received little attention within the history of the asylum.<sup>81</sup> When mentioned in broader asylum histories, the presence of the aged in the asylum has largely been offered as proof that it was being used as a receptacle for the unwanted and unproductive, thereby echoing the arguments made by contemporary asylum managers, discussed in Chapter Two of this thesis.<sup>82</sup> This position has been disputed by the only two historical asylum studies to look specifically at aged patients. The first of these, by Canadian historian Edgar-André Montigny, looks at the admission of aged patients to a Toronto asylum in the latter part of the nineteenth century. Montigny argues that the asylum constituted a ‘last desperate resort’ for families who chose to institutionalise their aged members.<sup>83</sup> The second is a largely quantitative study of aged patients admitted to two asylums in nineteenth-century Oxfordshire. Written by two clinicians, its principal finding is that the vast majority of aged patients showed a ‘florid and instantly recognizable psychopathology’.<sup>84</sup> Although it does not situate itself within wider historiographic debates, their article essentially

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<sup>80</sup> Margaret Morganroth Gullette, *Aged by Culture* (Chicago, 2004), p. 32.

<sup>81</sup> Child patients have received marginally more attention, although they were statistically far less common: Joseph Melling, Richard Adair and Bill Forsythe, ‘“A Proper Lunatic for Two Years”: Pauper Lunatic Children in Victorian and Edwardian England. Child Admissions to the Devon County Asylum, 1845-1914’, *Journal of Social History*, 31 (1997), pp. 371-405; Steven J. Taylor, ‘“All his Ways are That of an Idiot”: the Admission, Treatment of and Social Reaction to Two ‘Idiot’ Children of the Northampton Pauper Lunatic Asylum’, *Family & Community History*, 15 (2012), pp. 34-43; David Wright, *Mental Disability in Victorian England: the Earlswood Asylum, 1847-1901* (Oxford, 2001).

<sup>82</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (London, 1981), pp. 142-43.

<sup>83</sup> Edgar-André Montigny, ‘“Foisted Upon the Government”: Institutions and the Impact of Public Policy Ipon the Aged. The Elderly Patients of Rockwood Asylum, 1866-1906’, *Journal of Social History*, 28 (1995), p. 820.

<sup>84</sup> Yorston and Haw, ‘Old and Mad in Victorian Oxford: a Study of Patients Aged 60 and Over Admitted to the Warneford and Littlemore Asylums in the Nineteenth Century’, p. 418.

supports Montigny's argument: that aged patients were sent to the asylum because their behaviours sat comfortably within the boundaries of certifiable lunacy and presented significant challenges to the people around them.

The counter-revisionist historiography of the asylum has quite deliberately distanced itself from the theoretical models and categories of psychiatry. David Wright, in his influential 1997 article, 'Getting Out of the Asylum', argued that historians should start 'separating the history of confinement from the history of psychiatry'.<sup>85</sup> Even before this intervention from Wright, counter-revisionist histories of the asylum were primarily social histories, seeking to understand the place of asylums within the local communities that used them.<sup>86</sup> In more recent years, a handful of historical studies have attempted to insert medicine back into the history of the asylum, and to reintegrate the theory and practice of psychiatry in the nineteenth century. This has been done partly through studies of particular clinical and diagnostic categories. Hilary Marland's book, *Dangerous Motherhood*, uses a wide range of historical material to examine the medical understanding, treatment and experience of puerperal insanity amongst British women from across the social spectrum.<sup>87</sup> In *The Cruel Madness of Love*, Gayle Davis examines the classification, management and treatment of General Paralysis of the Insane (GPI) and syphilitic insanity, situating the development of psychiatric knowledge about these conditions within a clinical context.<sup>88</sup> This thesis follows the path indicated by Marland and Davis, taking seriously the social and practical aspects of asylum management, admission and care, but keeping in mind the status of the asylum as a medical institution. Chapter Four in particular demonstrates the way in which, through internally and externally directed changes to asylum record-keeping

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<sup>85</sup> Wright, 'Getting out of the Asylum', p. 139.

<sup>86</sup> See for example John K. Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848-50', *Journal of Social History*, 13 (1979), pp. 1-22; John K. Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-70', in William F. Bynum, Roy Porter and Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume II: Institutions and Society* (London, 1985), pp. 132-146.

<sup>87</sup> Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke, 2004).

<sup>88</sup> Davis, *The Cruel Madness of Love*.

practices, the shifting categories and priorities of psychiatric theory encroached upon even the most conservative institutions.

## The History of Old Age

The historiography of old age is somewhat less well-developed than that of the asylum, although interest in the topic has increased as the experience of ageing has itself become more widespread. Studies pertaining to the history of old age first began to appear in the 1960s, but research into the field did not begin in earnest until the late 1970s. Histories of old age have centred around two broad, overlapping themes: responsibility and dependence, and social and medical problematisation. Both have significant implications for this thesis.

The first of these themes concerns the social realities of living to old age, and the political interventions which have mediated the problems a long life can bring. One of the earliest concerns of the history of old age was to debunk the so-called 'golden age' myth, of an unspecified pre-modern past 'in which older people were venerated by their community and cared for by their family'.<sup>89</sup> In 1969, Peter Laslett famously announced that household size in England has been consistently small at least as far back as the sixteenth century. He suggested that the average household size from this time until the nineteenth century was 4.75, precluding a widespread pattern of multigenerational cohabitation.<sup>90</sup> Although this precise figure has been challenged over the last 50 years, even by Laslett himself, the broader conclusion that old people did not usually live with their children continues to be largely accepted.<sup>91</sup> This has led to the recognition, not that older people have been historically neglected, but that the 'locus of responsibility for the elderly' spread

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<sup>89</sup> Paul Johnson, 'Historical Readings of Old Age and Ageing', in Paul Johnson and Pat Thane (ed.), *Old Age from Antiquity to Post-Modernity* (London, 1998), p. 2; Peter N. Stearns, *Old Age in European Society: the Case of France* (London, 1977), p. 11; W. Andrew Achenbaum, *Old Age in the New Land: the American Experience since 1790* (Baltimore, 1978), p. 4; Carole Haber, *Beyond Sixty-Five: the Dilemma of Old Age in America's Past* (Cambridge, 1983), p. 5.

<sup>90</sup> Peter Laslett, 'Size and Structure of the Household in England Over Three Centuries', *Population Studies*, 23 (1969), p. 200.

<sup>91</sup> For more discussion of this, see pp. 157-159.

beyond the family, and included 'the community, and older individuals themselves'.<sup>92</sup>

Ideally, as Susannah Ottaway and Pat Thane have argued, older people in the eighteenth and nineteenth centuries lived in a state of 'negotiated independence': supporting themselves as far as possible, but drawing on a patchwork of familial, charitable and state support if their own means, or their ability to work, failed.<sup>93</sup> Charitable and voluntary organisations – such as friendly societies, almshouses, and homes for the aged poor – have undoubtedly played an important role in supporting the aged for many centuries, but the comparative sparseness of their records means that there is little known about the extent of charitable contributions.<sup>94</sup> In contrast, there is much to be read and said about state interventions into old age. Under the Old Poor Law, from at least the seventeenth century, a 'significant minority' of old people received some form of pension, paid from the local rates.<sup>95</sup> According to Ottaway, the eighteenth century saw a significant increase in the proportion of older people receiving poor relief.<sup>96</sup> By the end of the nineteenth century, when national statistics on old-age pauperism were first collected, three out of every ten people aged 65 or over were receiving assistance through the Poor Law.<sup>97</sup> After the passage of the 1834 Poor Law Act, relief had increasingly moved indoors (into the workhouse), but out-relief remained the primary source of Poor Law support for aged paupers across England as a

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<sup>92</sup> Ottaway, *The Decline of Life*, p. 7.

<sup>93</sup> Pat Thane, *Old Age in English History: Past Experiences, Present Issues* (Oxford, 2000), pp. 123, 434, 480; Ottaway, *The Decline of Life*, p. 1.

<sup>94</sup> Nigel Goose and Stuart Basten, 'Almshouse Residency in Nineteenth Century England: an Interim Report', *Family & Community History*, 12 (2009), pp. 65-76; Carmen M. Mangion, 'Faith, Philanthropy and the Aged Poor in Nineteenth-Century England and Wales', *European Review of History*, 19 (2012), pp. 515-30. Friendly societies have been much more extensively studied, see for example: P. H. J. H. Gosden, *Self-help; Voluntary Associations in the Nineteenth Century* (London, 1973); Simon Cordery, *British Friendly Societies, 1750-1914* (Houndmills, 2003); Martin Gorsky, 'Friendly Society Health Insurance in Nineteenth-Century England', in Martin Gorsky and Sally Sheard (es.), *Financing Medicine: The British Experience Since 1750* (London, 2006), p. 147-64.

<sup>95</sup> Richard Smith, 'Ageing and Well-Being in Early Modern England' in Johnson and Thane (eds) *Old Age from Antiquity to Post-Modernity*, p. 88.

<sup>96</sup> Ottaway, *The Decline of Life*, pp. 10-12.

<sup>97</sup> Boyer and Schmidle, 'Poverty Among the Elderly in Late Victorian England', p. 374.

whole.<sup>98</sup> In London, however, as already discussed, out-relief was greatly restricted, and the majority of aged paupers were relieved in the workhouse.<sup>99</sup>

Although older people made up a large proportion of workhouse inmates in London, entering the workhouse remained a deeply stigmatised and dreaded act, and many of the poorest elderly preferred to struggle on in the most abject poverty, getting by on the most menial of work with support from family and friends.<sup>100</sup> This came to light in the 1880s, through the poverty surveys undertaken by Charles Booth. His systematic study of income and living conditions in London led Booth to conclude that 'on the whole, people are poor because they are old'.<sup>101</sup> This sparked a wave of political debate on the question of old-age poverty, and a Royal Commission was set up in 1895 to investigate the problem of the 'Aged Poor'.<sup>102</sup> After two decades of public debate and political wrangling, a non-contributory state pension – designed to help, but not fully support, the respectable aged poor – was finally introduced in 1908.<sup>103</sup> This was significant, in that it recognised the limits of thrift to ensure a comfortable old age, but it contained many limitations: the pensionable age was set at 70, and residents of Poor Law institutions – including the asylum – were ineligible.<sup>104</sup>

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<sup>98</sup> Boyer and Schmidle, 'Poverty Among the Elderly in Late Victorian England', p. 251. David Thomson, who has written prolifically on poor relief for the aged, has argued that the poor law was particularly generous to the aged in the early-mid nineteenth century, providing what essentially amounted to a pension of greater value than the 1908 state pension. However, the way he has chosen to interpret the data from his small case study has come under significant criticism. David Thomson, 'The Decline of Social Welfare: Falling State Support for the Elderly Since Early Victorian Times', *Ageing & Society*, 4 (1984), pp. 451-82; E. H. Hunt, 'Paupers and Pensioners: Past and Present', *Ageing & Society*, 9 (1989), pp. 407-30.

<sup>99</sup> The workhouse was not a monolith, especially in London. By the 1870s, London had a well-developed network of specialized workhouse institutions, some of which offered medical care as well as relief. Mary MacKinnon has argued that the enhanced medical role of workhouses in urban centres made older people more willing to enter them. Mary MacKinnon, 'Poor Law Policy, Unemployment, and Pauperism', *Explorations in Economic History*, 23 (1986), pp. 326-27.

<sup>100</sup> John MacNichol, *The Politics of Retirement in Britain, 1878-1948* (Cambridge, 1998), pp. 18-59. Retirement was a feature of few people's lives in the nineteenth century, but the threat of being relieved from employment due to old age or infirmity was real, and lay at the centre of the anxieties of many of Hanwell's older patients, as discussed in Chapter Four.

<sup>101</sup> Charles Booth, *The Aged Poor in England and Wales* (London, 1894), p. 54.

<sup>102</sup> Thane, *Old Age in English History*, pp. 173-215.

<sup>103</sup> Thane, *Old Age in English History*, pp. 215-35.

<sup>104</sup> Macnicol, *The Politics of Retirement in Britain*, pp. 155-63; Martin Pugh, 'Working-Class Experience and State Social Welfare, 1908-1914: Old Age Pensions Reconsidered', *The Historical Journal*, 45 (2002), pp. 775-96.

Thus, the 'golden age' myth can be countered with a reverse narrative: over the long nineteenth century and into the twentieth century, social policies were enacted which offered an increasingly generous and stable financial safety net to the dependent aged. This narrative, however, is not always presented in such a positive light. Much of the original impetus for the history of old age was driven by the recognition of a specific form of age-based discrimination, 'ageism'.<sup>105</sup> Thus, despite rejecting a 'golden age' myth, historians inspired by this political project have set out to account for the apparent social and cultural marginalisation of the aged in the late-twentieth century.<sup>106</sup> Historians such as Andrew Achenbaum, Carole Haber and Stephen Katz have suggested that the creation of formal support structures was achieved at the expense of the dignity and cultural value accorded to old age. The establishment of widespread retirement and pensions in the late-nineteenth and twentieth centuries, they argue, has fostered a social and cultural differentiation between old age and youth, and reinforced the image of old people as a superannuated, dependent burden.<sup>107</sup>

'Expert knowledge', both social and medical, is key to these accounts of differentiation and marginalisation.<sup>108</sup> Booth's social surveys, and other projects and discourses which drew attention to the plight of the aged poor, are framed as part of a 'modern movement away from understanding ageing primarily as an existential problem requiring moral and spiritual commitment, toward understanding it primarily as a scientific problem amenable to technical solution'.<sup>109</sup> The medical history of old age has been drawn into this narrative of marginalisation

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<sup>105</sup> The term 'ageism' was coined in 1968, by American gerontologist Robert Butler. Ballenger, *Self, Senility, and Alzheimer's Disease in Modern America*, p. 75.

<sup>106</sup> It should be noted that this is a particularly American tendency, including works written by North Americans about Europe. The two major works in the history of old age which do not follow this narrative – one, an edited collection, the other a monograph – were produced by British social historians: Margaret Pelling and Richard M. Smith, *Life, Death and the Elderly: Historical Perspectives* (London, 1991); Thane, *Old Age in English History*.

<sup>107</sup> Achenbaum, *Old Age in the New Land: the American Experience since 1790*, pp. 110-17; Haber, *Beyond Sixty-Five*, pp. 108-30; Stephen Katz, *Disciplining Old Age: the Formation of Gerontological Knowledge* (Charlottesville, 1996), pp. 61-67. See also Ottaway, *The Decline of Life*, pp. 10-12; Peter Townsend, 'The Structured Dependency of the Elderly: A Creation of Social Policy in the Twentieth Century', *Ageing & Society*, 1 (1981), pp. 5-28.

<sup>108</sup> Carole Haber uses this particular term: Haber, *Beyond Sixty-Five*, p. 7.

<sup>109</sup> Katz, *Disciplining Old Age*, p. xxiv.

and problematisation. The term 'geriatrics' was coined in 1909, but numerous historians have dated the origins of a medical speciality in old age and ageing to early-nineteenth-century France.<sup>110</sup> In the 1830s and 1840s, the pathological anatomists of the Paris School identified structural differences between old bodies and younger bodies which, these historians argue, created a new medical understanding of old people as 'inherently separate and inevitably pathological'.<sup>111</sup> The subsequent development of a specialised medical literature on old age was thus a partner to the social investigations and interventions which defined the aged as a distinctive, problematic section of the population.

This thesis shows that, while useful, this broader historiography of old age cannot fully account for the position of mentally disordered older people. The 'senile' emerged as a problematic group at the same time as the 'aged poor', but attitudes and responses towards them were very different. Despite being amongst the most deserving of the indigent poor – a group whose sufferings were attributed to the '*natural* infirmity of old age' – the problem of the senile did not provoke the same sympathetic and enthusiastic response as the general aged population. As will be argued in Chapter Two, the solutions offered to the problem of the senile poor were aimed entirely at displacing responsibility for their care, rather than seeking sustainable and humane alternatives. The medicalisation narrative offered by Katz and Haber – the suggestion that old age became more decisively embodied over the course of the nineteenth century, with greater emphasis placed on the pathological signs of ageing – has offered a useful starting point for the understandings of old age examined here. However, this thesis will show that 'pathologisation' is an insufficient term to describe the changing understanding of

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<sup>110</sup> More recently, Daniel Schaefer has shown that a substantial body of medical writings on old age existed prior to the nineteenth century. Daniel Schaefer, *Old Age and Disease in Early Modern Medicine* (London, 2010).

<sup>111</sup> Katz, *Disciplining Old Age*, pp. 8, 41-43; Carole Haber, 'Geriatrics', in David D. Van Tassel and Peter N. Stearns (ed.), *Old age in a Bureaucratic Society: the Elderly, the Experts, and the State in American History* (Westport, 1986), pp. 70-79; David G. Troyansky, *Old Age in the Old Regime: Image and Experience in Eighteenth-Century France* (Ithaca, 1989), p. 122; W. Andrew Achenbaum, *Crossing Frontiers: Gerontology Emerges as a Science* (New York, 1995), pp. 36-37; Thomas R. Cole, *The Journey of Life: a Cultural History of Aging in America* (Cambridge, 1992), pp. 198-202. For 'Paris medicine' more generally see Erwin Heinz Ackerknecht, *Medicine at the Paris Hospital, 1794-1848* (Baltimore, 1967); Caroline Hannaway and Ann Elizabeth Fowler La Berge, *Constructing Paris medicine* (Amsterdam, 1998).



the ageing process in the nineteenth century. Indeed, it was the very ‘naturalness’ of old-age infirmity which marked its sufferers as different, and as a problem.

### **Sources, Approaches and Arguments**

This thesis draws on three main sets of sources: published articles, treatises and textbooks dedicated to the classification, treatment and pathology of insanity; administrative documents – particularly annual reports – relating to the management of asylums at a national and local level; and patient records from Hanwell. Each chapter focusses on one of these sets of sources. The final section of this introduction, then, will outline the sources and approaches mobilised in each chapter, along with the key questions asked, and arguments made. Finally, the arguments of the thesis as a whole, cutting across all of the chapters, will be summarised.

The first chapter of this thesis draws on psychiatric literature published between 1835, when the term ‘senile dementia’ first appeared in print, and 1910, when German psychiatrist Emil Kraepelin coined the term ‘Alzheimer’s Disease’.<sup>112</sup> These include the major textbooks and treatises on insanity published by British psychiatrists during this period – identified through secondary research and through references within these texts – and articles in the *Journal of Mental Science*, *Brain*, the *British Medical Journal* and *The Lancet* – identified through key-word searches of digital databases. Four key issues were examined within these texts: the place of senility and dementia in classifications of forms of insanity, the symptoms associated with dementia, the models of the ageing process which psychiatrists employed, and the use and meaning of the metaphor of second childhood.

This chapter uses the shifting place of ‘senility’ within the classification of mental disorder as a starting point to examine the relationship between insanity and old age, and relates these shifts to broader changes within psychiatric knowledge. It shows how emerging theories within psychiatry – particularly cerebral

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<sup>112</sup> James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind* (London, 1835), pp. 84-99; Ballenger, *Self, Senility, and Alzheimer's Disease in Modern America*, pp. 41-43.

localisation and the theory of dissolution – drew on and influenced models of ageing and dementia. It argues that these developments reinforced the existent resonances between the categories of senility and dementia, and thus argues that the emergence of senile dementia as the ‘prototype of senility’ at the beginning of the twentieth century was underpinned by a carefully considered and materially based psychiatric epistemology. Senility before Alzheimer, then, was not ignored by psychiatrists, but held a central place in wider theories of insanity and mental disorder.

On the 1st January 1851, there were 7, 851 patients resident in county and borough asylums in England and Wales.<sup>113</sup> On 1st January 1901, there were almost ten times that number: 75, 916.<sup>114</sup> At the end of the nineteenth century London’s asylum population was the largest in the country, even in proportion to its enormous overall population.<sup>115</sup> The question of how and by whom such a large population, and the vast financial outlay it required, should be managed, was a deeply political one, cutting across the competing interests of various bureaucratic entities, from asylum managers, to Poor Law officials, to the local magistracy. The second chapter of this thesis examines the ‘policy’ of psychiatry: the way in which the groups charged with organising the provision of care and treatment for the insane went about their task, and their attitudes towards it. This chapter argues that the administrators of lunacy strove to exclude senile patients from their institutions and, in doing so, fostered a particular understanding of old-age mental disorder: one which de-legitimised the claim of senile patients to asylum care, and excluded them from the ranks of the ‘truly’ insane.

The main source base for this chapter is a set of published administrative texts – annual reports and published minutes of meetings – produced by the national Lunacy Commissioners (who inspected and reported on the care and treatment of insanity across the whole of England and Wales), the MAB and its

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<sup>113</sup> *The Fifth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1851), p. 2.

<sup>114</sup> *The Fifty-Fifth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1901), p. 2.

<sup>115</sup> David Cochrane, “‘Humane, Economical and Medical Wise’: the LCC as Administrators of Victorian Lunacy in Bynum and Porter (eds), *Anatomy of Madness*, Vol. III, pp. 248-50.

individual asylum committees, and the managing committee of Hanwell. This was supplemented by the annual reports of the medical officers of Hanwell and Caterham asylums, and by letters and articles published in the medical press, in which asylum Superintendents and Poor Law medical officers put forward their case for not taking responsibility for senile patients. Together, these sources present an account of the steps taken to manage and mitigate the problems of dealing with the ever-growing asylum population – including a large and unwelcome contingent of age patients – but they also represent a discourse within which the ideal attributes of the asylum population was defined. Chapter Two, then, examines the literal and discursive attempts to exclude the senile from the ranks of the insane.

The third, fourth and fifth chapters of this thesis draw on the patient records of Hanwell: specifically on the case notes of the 381 patients who were (recorded as) aged 60 or over at the time of their admission, in the years 1851-52, 1871-72, 1891-92 and 1911-12. This breadth of sample was chosen in order to reveal some of the changes which took place over the long term, while keeping the sample at a manageable size to allow for meaningfully deep qualitative analysis. The case notes are rich, multifaceted documents, ‘themselves a form of record linkage’, which bring together demographic data regarding the patient’s age and status, the asylum medical officers’ impressions of their physical and mental condition on admission and during their residence, and narratives of the patient’s former life gleaned from their friends and relatives, with material produced outside the asylum, such as their medical certificates, and letters written by a variety of concerned parties.<sup>116</sup> The potential of patient case notes is now widely recognised by historians and other scholars, as ‘the surest basis we have for understanding the changing nature of the experience of the insane in asylums’, as a ‘vehicle’ for examining ‘what physicians...did’ alongside what they ‘said’, and as the site where ‘the identity of the asylum patient was invented’.<sup>117</sup> Patient case notes, then, are rich with interpretive

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<sup>116</sup> Davis, *The Cruel Madness of Love*, p. 28.

<sup>117</sup> Andrews, ‘Case Notes, Case Histories’, p. 255; Guenter B. Risse and John Harley Warner, ‘Reconstructing Clinical Activities: Patient Records in Medical History’, *Social History of Medicine*, 5 (1992), p. 183, quoting from Edwin Ackerknecht, ‘A Plea for a “Behaviourist Approach” in the Writing

possibilities, offering insights into the discourse, practice and experience of medicine. This thesis seeks to exploit these multiple possibilities, by taking a different approach to the case notes in each of the last three chapters.

Chapter Three follows the methodology indicated by David Wright, using the case notes to 'examine the interface of institutional and non-institutional care and control'.<sup>118</sup> It seeks to understand why older people came to be admitted to Hanwell. The case notes were thus examined for evidence of the patients' domestic circumstances prior to their institutionalisation. This evidence was then placed in the wider context of the history of the family, and the social and demographic landscape of nineteenth-century London. This was used to build up a picture of the wide range of responses to the aged, mentally disordered poor within the family and community, and the events which eventually led them to Hanwell. Thus, this chapter offers insight into the place of the dependent aged within the family and the community, as well as the reasons for which people came to enter a lunatic asylum at an advanced age.

Chapter Four takes a very different approach, focussing less on the information contained within the case notes, and more on the structure of the case notes themselves. It shows that the use of the word 'senile' to describe aged patients increased significantly at the end of the nineteenth century, as did the overall tendency to attribute older patients' disorders to their aged state. It places this change within the context of the changing structure of the case books and the admissions registers over this period, and the ways in which this shaped and reflected the activities and attitudes of Hanwell's medical officers. In doing so, it argues that the theoretical concerns discussed in Chapter One were reflected in, and contingent upon, asylum practice, and that this had a significant impact on the categorisation and description of older patients.

Finally, Chapter Five blends the approach of both of these chapters, in an examination of the two routes out of the asylum: the discharge of recovered or

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of the History of Medicine', *Journal of the History of Medicine and Allied Sciences*, 22 (1967), pp. 211-114; Coleborne, *Reading 'Madness'*, p. 58.

<sup>118</sup> Wright, 'Getting out of the Asylum', p. 145.

improved patients, and the care of the dying. This chapter uses the case notes to show 'what doctors did' to ill and dying patients in the asylum, and to gain insight into the factors which contributed to the decision to discharge older patients to the home, or to another institution. At the same time, however, it recognises that the case notes offer us a mediated picture of what went on in the asylum: they are 'innately jaundiced', limited by the interests and concerns of the medical officers who wrote them.<sup>119</sup> It shows that the most controversial and problematic instances of patient death and discharge – about which the most was written – alert us to the constructed nature of the case notes, as an official record of events more than a straightforward description of them.

This thesis makes three key arguments. Firstly, it argues that senility became a more important and prevalent category in psychiatric discourse over the course of the second half of the nineteenth century. During that period, psychiatrists increasingly came to view older people *as* old: old mentally-disordered people were more likely to be labelled as 'senile', and their disorders linked explicitly to structural changes within their aged bodies. This can be seen in the proliferation of different forms of senile insanities in both theoretical texts and in asylum practice, and in the increasing use of the word senile to describe older patients in asylum patient records. At the same time, this increasingly visible cohort of categorically senile patients was described as a problematic group within the broader asylum population. Indeed, it is partly through the problematisation of aged asylum patients that the senile patient emerged as a clearly-defined subject.

Secondly, it argues that, at the very end of the nineteenth century, dementia became the prototype of senility. That is to say, that dementia came to be seen as the only mental disorder which was truly an expression of the ageing process, and that older, mentally disordered people were increasingly likely to be labelled as 'demented'. A corollary to this argument is that dementia was not always the prototype of senility. For most of the late-nineteenth century, psychiatric texts contained many different categories of senile insanity, and old asylum patients were

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<sup>119</sup> Andrews, 'Case Notes, Case Histories', p. 266.

similarly diagnosed with a variety of 'senile' mental disorders. The limiting of senility to dementia did not only effect a change in nomenclature, it produced a particular idea of what a senile person was: intellectually incompetent, evolutionarily regressive, irretrievably decaying, and essentially harmless. This was particularly evident in the administrative discourses surrounding the management of the asylum, where a particular image of the 'senile' was propagated, in order to legitimate their exclusion from asylum care: as manageable, incurable, and suffering from natural decay rather than a pathological condition.

Finally, this thesis argues that the senile represented an intractable problem in nineteenth-century society. The examination of asylum patient records shows that old people ended up in the asylum because they had transcended the ability of the people around them – in the home, in the community or in the workhouse – to manage their behaviour. There was no specialised institutional provision for the care of the aged, mentally disordered poor, and many of them ended up in the asylum by default. This situation was not accepted by the administrators of senility, but neither were workhouse officials prepared to tolerate the presence of disruptive older people. The senile were thus a residual group, perpetually displaced from one site of care and management to another – both rhetorically and literally – but never settling into a welcoming home.

## Chapter One: Senility, Dementia and Dissolution in Psychiatric Theory

The student... is too apt to assume that all varieties of mental ailments in the aged issue in senile dementia... [Senile insanity] connotes a very large class of symptoms, embracing between them all the varied forms of insanity usually differentiated.<sup>1</sup>

This warning, written by psychiatrist William Bevan Lewis (1847-1940) in 1889, is as useful to the historian as it was to the nineteenth-century student of psychiatry. The term 'senile dementia' came into common usage in the second half of the nineteenth century. Broadly speaking, a 'senile dement' from the nineteenth century would be recognised now: a conspicuously old person, showing signs of confusion, memory loss and disorientation, eventually losing language and comprehension. Yet this apparent continuity masks significant changes to the understanding and meaning attached to these terms which have taken place over the last 200 years. As Bevan Lewis was keen to point out, 'senile dementia' was not the only recognised form of 'senile insanity' in the nineteenth century: many of his contemporaries thought that mental senility could manifest in a variety of different ways, and that any form of insanity which erupted from an aged body was inherently altered by it, 'stamped with a special impress which more or less distinguish forms of senile alienation from the psychosis of earlier periods of life'.<sup>2</sup> At the same time, the term 'dementia' did not always have to mean 'senile dementia': dementia had long been recognised as a process of severe mental deterioration which could affect people at any age, particularly the chronically insane. The relationship between these two categories was not stable at any point during this period, and this chapter seeks to chart and account for these shifts.

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<sup>1</sup> William Bevan Lewis, *A Text-book of Mental Diseases: with Special Reference to the Pathological Aspects of Insanity* (London, 1889), p. 405.

<sup>2</sup> *Ibid.*, p. 406.

In 1984 clinician-historian, German Berrios, first outlined his approach to the history of psychiatric theory, 'the history of descriptive psychopathology'.<sup>3</sup> This chapter broadly follows his call to ask 'specific questions about the genesis of descriptive psychopathological categories and about their interaction with the psychological and philosophical context.'<sup>4</sup> It will adopt the same method of tracing the classification and description of senility and dementia through published psychiatric texts, and setting them within their wider intellectual context. The vast majority of the existent work on the history of dementia has been written by Berrios, and this chapter uses his work as a starting point for a number of themes.<sup>5</sup> Nevertheless, it cannot provide stable definitions suitable for the 'calibration technique by means of which the language of psychiatry [can be] conceptually tightened' that Berrios seeks.<sup>6</sup> The ambiguity of dementia and senility as concepts are ever-present in this analysis, and should not be erased.

There is no single story to be told about the way that the concepts of senility and dementia developed in nineteenth-century psychiatry. Thus, this chapter takes a multi-stranded, thematic approach, looking sequentially at classification, symptoms, the ageing body, and the idea of 'second childhood'. There is, however, a common chronological narrative through which each theme is successively traced. The chronological narrative mobilised in this chapter has three stages, based around three key ideas which stimulated a change in the way that senility and dementia were understood in British psychiatry. The first period technically begins with the first usage of 'senile dementia' in English, in James Cowles Prichard's (1786-1848) 1835 book, *A Treatise on Insanity*. Its roots, however, belong in turn-of-the-century France, with the work of Phillipe Pinel (1755-1826) and his student, Jean Étienne

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<sup>3</sup> G. E. Berrios, 'Descriptive Psychopathology: Conceptual and Historical Aspects', *Psychological Medicine*, 14 (1984), pp. 303-13.

<sup>4</sup> Ibid., p. 308.

<sup>5</sup> See for example G. E. Berrios, 'Dementia: Clinical section', in G. E. Berrios and Roy Porter (eds), *A History of Clinical Psychiatry: the Origin and History of Psychiatric Disorders* (London, 1995), pp. 34-51; G. E. Berrios, 'Dementia During the Seventeenth and Eighteenth Centuries: a Conceptual History', *Psychological Medicine*, 17 (1987), pp. 829-37; G. E. Berrios, 'Memory and the Cognitive Paradigm of Dementia During the Nineteenth-Century: a Conceptual History', in R. M. Murray and Trevor Turner (eds), *Lectures on the History of Psychiatry* (London, 1990), pp. 194-211; G. E. Berrios and Hugh L. Freeman, *Alzheimer and the Dementias* (London, 1991).

<sup>6</sup> Berrios, 'Descriptive Psychopathology', p. 310.



Esquirol (1772-1840). This is the least clearly defined period, but its most salient feature is a symptomological approach to psychiatric classification. This approach was challenged in the 1860s, initially by Auguste Morel (1809-73) in France, and by David Skae (1814-1873) in Edinburgh. David Skae's 'natural history' approach to psychiatric classification, first outlined in an article in the *Journal of Mental Science* in 1863, was an ambitious attempt to classify mental diseases by their underlying physical cause. Skae's scheme cannot in itself be described as influential, as it 'does not appear to have been seriously employed at any other asylum'.<sup>7</sup> However, this chapter will argue that the 'somato-aetiological' approach to mental disorder, of which Skae's work is an early manifestation, was widely approved of, with profound implications for the classification of old-age mental disorders. The third chronological period in this narrative overlaps significantly with the second, beginning around the 1870s. It centres primarily on the work of neurologist John Hughlings Jackson (1835-1911), and on research undertaken at the West Riding Asylum at Wakefield which became, in the 1870s and 80s, the centre of British scientific research into psychiatry and the brain.<sup>8</sup> The key idea advanced in this period was that insanity was a form of 'dissolution', an evolutionary reversal in which the sufferer reverted to a simpler, less developed state. This, too, had significant implications for the way that ageing and dementia were understood. This periodisation is not only overlapping, but also somewhat artificial. William Bevan Lewis, for example, was very much a Wakefield man, and an adherent of the doctrine of dissolution, but his classificatory scheme was of the somato-aetiological type expounded by Skae and his student, Thomas Clouston (1840-1915). Nevertheless, it provides a useful analytical framework through which the diverse changes in the concepts of senility and dementia in British psychiatry can be understood.

This chronology, then, informs each of the four thematic sections of this chapter. The first section concerns the place of old age, and of dementia, in the

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<sup>7</sup> Gayle Davis, *The Cruel Madness of Love: Sex, Syphilis and Psychiatry in Scotland, 1880-1930* (Amsterdam, 2008), p. 86.

<sup>8</sup> Michael Anthony Finn, 'The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century', (PhD Thesis, University of Leeds, 2012).

classificatory schema produced by psychiatrists throughout this period. It argues that the categories of 'senility' and 'dementia' were significantly intertwined from the beginning of this period, but that this close relationship was disrupted by the somato-aetiological classificatory thinking which emerged in the second half of the nineteenth century. At the end of the century, however, the theory of dissolution once again drew attention to the conceptual resonance between dementia and ageing, and 'senile dementia' became the dominant 'senile' classificatory category. The second section concentrates just on 'dementia', and on the way in which this condition was described and explained. It argues that, at the beginning of this period, dementia was understood primarily as a failure of sensation, but that by the turn of the century, it was understood primarily as a failure of reason. The third section looks at the different models of ageing (explanations of the ageing process) which were mobilised in these texts, particularly at the 'vital energy' model and the 'atrophic' model. It argues that both of these models of physiological ageing served to reinforce the relationship between senility and dementia. The fourth section looks at one particular metaphor mobilised in these texts, of senility as 'second childhood', and argues that theories of dissolution and degeneration imbued this ancient metaphor with new meanings. In concluding, this chapter will then turn to the issue which has animated historians of dementia and ageing in the twentieth and twenty-first centuries: was mental degeneration and insanity in old age considered natural or pathological? It will show that, although senility and dementia came to be viewed as structurally identical phenomena in the latter nineteenth century, most psychiatrists still worked very hard to maintain a qualitative distinction between natural senility and pathological senile dementia.

If there is an overarching narrative present in this chapter, it concerns the effects of the increasing biologisation of mental illness in the second half of the nineteenth century, and of the evolutionary (and dissolutionary) thinking on which much of this neuro-psychiatric theory was based. The former decisively tied the mental ailments of old age to the processes of physical disintegration, and the latter gave both form and meaning to the resultant mental degeneration. The greater the emphasis placed on the physical dimension of mental ailments, the more important

became the conceptual congruence between dementia (a progressive stripping away of a person's mental capacities), ageing (a progressive disintegration of the body) and, eventually, degeneration (a progressive undoing of the evolutionary process). Through this conceptual triangulation – of psychiatric, physiological and evolutionary knowledge – the senile dement was fixed as a person who was mentally inferior, primitive, childlike, and half-dead.

## **The Classification of Senility and Dementia in Nineteenth-Century Psychiatry**

As Bevan Lewis' statement above suggests, there were many types of senile insanity in the nineteenth century. Senile mania, melancholia, and dementia were the most commonly mentioned, but other categories such as senile epilepsy, senile paralysis and senile imbecility also appear in these texts. There were also several types of dementia: acute and chronic, primary (appearing at the onset of insanity) and secondary (appearing after a long attack of a different form of insanity), epileptic and paralytic. This section traces the emergence and disappearance of these categories in the classificatory schema published by British psychiatrists between the 1830s and the early twentieth century. At no point during this period was there a universally approved system for the classification of insanities. Although psychiatrists bemoaned the inadequacies of existent classificatory schemes, attempts to radically update them were met with bemusement or even hostility.<sup>9</sup> Nevertheless, a certain amount of classificatory development did take place, and the way in which 'senility' and 'dementia' were featured in these classificatory schema underwent a number of changes over this period. German Berrios has argued that, although there were many types of dementia during the nineteenth century, the senile type eventually became the most important: 'By 1900, senility was the prototype of dementia'. This section will examine this thesis. As there were also many types of senile insanity during this period, this section will also look at

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<sup>9</sup> See for example James Crichton Browne, 'Skae's Classification of Mental Diseases: A Critique', *Journal of Mental Science*, 21 (1875), pp. 339-65.

Berrios' claim from the opposite direction: to what extent, by the turn of the century, was dementia the prototype of senility?

*James Cowles Prichard, and Dementia as Loss*

The term 'senile dementia' first appeared in 1835, in James Cowles Prichard's *Treatise on Insanity and Other Disorders Affecting the Mind*, although the similar term 'senile demency' had been used in another text, written by George Man Burrows (1771-1846), in 1828.<sup>10</sup> Both were anglicisations of the French term *démence sénile*. The term 'dementia' on its own had a much longer history. German Berrios has traced the English usage of the word 'dementia' to the late-seventeenth century, and the French usage at least as far back as the fourteenth. He suggests that the concept of dementia – 'cognitive failure, chronic behavioural dislocation, and psychosocial incompetence' – developed under different names, and did not become attached exclusively to the word 'dementia' until the eighteenth century.<sup>11</sup> Though no doubt informed by this longer history, Prichard's and Burrows' descriptions of dementia, drew explicitly on the same specific sources: the work of turn-of-the-century Parisian psychiatrist Phillipe Pinel and his student, Jean-Étienne Esquirol.

In both Pinel and Esquirol's work, dementia was aligned with idiocy and imbecility. Symptomatically, the two conditions were very similar. Both rendered the sufferer 'fatuous': confused, unable to understand their surroundings, and unable to reason reliably. However, while Pinel often conflated the two categories, Esquirol drew a firm line between them:

The imbecile...have [*sic*] never possessed the faculties of understanding in a state sufficiently developed for the display of reason. The victim of dementia was once endowed of them but has lost possession.<sup>12</sup>

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<sup>10</sup> James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind* (London, 1835), pp. 84-99; George Man Burrows, *Commentaries on the Causes, Forms, Symptoms, and Treatment, Moral and Medical, of Insanity* (London, 1828), p. 489.

<sup>11</sup> Berrios, 'Dementia During the Seventeenth and Eighteenth Centuries: a Conceptual History', pp. 830-36.

<sup>12</sup> Prichard, *Treatise on Insanity*, pp. 85-86.

Imbecility, according to Esquirol, was always congenital, whilst dementia was always acquired; idiocy was characterised by under-development, while dementia was characterised by loss. This key point of differentiation – dementia as loss, rather than aberration or absence – was to be the central component of the dementia concept in British psychiatry for the rest of the century.

Prichard dedicated his *Treatise* to Esquirol, and called his description of dementia ‘the best and most original that has been drawn’. He also held loss at the centre of his own description of the disease.<sup>13</sup> Dementia, Prichard suggested, would always progress through four stages, each characterised by the loss of a different mental function: the first by loss of memory, the second by loss of reason, the third by loss of comprehension and the last by loss of instinct. A dement in the first stage – ‘forgetfulness’ – would be unable to form or retain new memories, but would still be able to reason correctly using any memories they already held, or regarding matters immediately in front of them. In the second stage – ‘irrationality’ – their loss of energy, which had already halted the retention of new impressions, would begin to impact on their ability to concentrate. Unable to follow a train of thought, a dement in the second stage would be unable to reason. In the third stage – ‘incomprehension’ – the sufferer would be unable to comprehend and engage with the world around them, and would sink into blank inactivity or the ceaseless repetition of old habits. Finally – in a state of ‘inappetency’ – even the deepest, ‘instinctive’ functions would be lost, rendering the sufferer barely able to control their own movements or ‘obey the calls of nature’. Not all cases would reach this final stage – due to recovery, plateau, or death – but any progression would always occur in this way. Dementia, then, was a regular, determined, dismantling of the mind, through which the sufferer lost their mental faculties in a hierarchical fashion, eventually losing their mind entirely, reduced to ‘mere...physical existence’.<sup>14</sup>

After Prichard, in the second half of the nineteenth century, the ancient categories of insanity such as ‘mania’ and ‘dementia’ were derided as mere

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<sup>13</sup> Ibid., p. 86.

<sup>14</sup> G. E. Berrios, 'Classic Text No. 37: J. C. Prichard and the Concept of 'Moral Insanity'', *History of Psychiatry*, 10 (1999), pp. 89-99.

collections of symptoms, bearing little relationship to underlying psychophysiological disorders.<sup>15</sup> For Prichard and his contemporaries, however, these categories signified distinct disease processes. For Prichard, the progressive mental deterioration of dementia was more than a superficial symptomatic phenomenon. Rather, he saw this progressive disintegration as a fundamental component of the disease itself. This underlined the relationship between dementia, ageing and decay, as processes which all involved progressive deterioration. At the same time, Prichard expressed uncertainty as to exactly how close the relationship between dementia and ageing was. On one hand, he recognised that many old people did not develop dementia. On the other, he thought that senile dementia was 'the change which time alone will perhaps sooner or later bring on, in those who long survive the allotted duration of man's days'.<sup>16</sup> Thus, he suggested that dementia would 'perhaps' appear in anyone who lived long enough. Prichard was unwilling to state explicitly that dementia was always a stage on the road to a 'natural death' from old age. His tentative statements, however, constitute a hypothesis, that senile dementia was a rendition of the process of decay and disintegration which led inevitably to death.

Prichard's textbook contained other forms of dementia, and another senile disorder, named simply 'senile insanity'. Prichard categorised this as a form of 'moral' insanity. His insistence on the existence of moral insanities, is perhaps Prichard's best-known contribution to psychiatry.<sup>17</sup> He broke with a Lockean model

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<sup>15</sup> As shall be discussed later, David Skae was one of the most determined opponents of symptomatic classification, along with those who studied and worked closely under him, such as Thomas Clouston and John Batty Tuke: David Skae, 'A Rational and Practical Classification of Insanity', *Journal of Mental Science*, 9 (1863), pp.312-13; T. S. Clouston, *Clinical Lectures on Mental Diseases* (London, 1883), pp. 16-20; J. Batty Tuke, 'A Plea For The Scientific Study Of Insanity', *Journal of Mental Science*, 1 (1891), pp. 1161-66. Others recognised the problems with symptomatic classification, but ultimately concluded that such a system was the most pragmatically useful, eg. John Charles Bucknill and Daniel Hack Tuke, *A Manual of Psychological Medicine* (1st edn, London, 1858), pp. 85-100; George Fielding Blandford, *Insanity and its Treatment: Lectures on the Treatment, Medical and Legal, of Insane Patients* (London, 1871), p. 115; Henry Maudsley, *Responsibility in Mental Disease* (London, 1874), pp. 73, 83-84; George H. Savage, 'Cases of Senile Insanity, with Remarks', *Journal of Mental Science*, 29 (1883), pp. 10-15.

<sup>16</sup> Prichard, *Treatise on Insanity*, p. 92.

<sup>17</sup> Hannah Franziska Augstein, 'J C Prichard's Concept of Moral Insanity: a Medical Theory of the Corruption of Human Nature', *Medical History*, 40 (1996), pp. 311-43; Berrios, 'J. C. Prichard and the Concept of 'Moral Insanity''; Joel Peter Eigen, *Witnessing Insanity: Madness and Mad-Doctors in the*

of insanity, in which madness is understood as reasoning from incorrect beliefs, by suggesting that a mad person could be entirely rational and free from delusion. The moral insanities, he claimed, manifested in unusual or perverse behaviour, or uncontrolled or excessive emotion. Senile insanity – as a form of moral insanity – was thus a disorder of the feeling rather than the intellect, and as such was entirely distinct from senile dementia. It involved a marked reversal of the person's long-held character and tendencies: 'The pious... become impious, the content and happy discontented and miserable, the prudent and economical imprudent and ridiculously profuse, the liberal penurious, the sober drunken'.<sup>18</sup> Prichard suggested that any moral insanity which appeared for the first time in old age should be considered a 'senile' insanity, but maintained that this was a rare event, and that senile insanity was not a common accompaniment of old age. It was a 'modification of madness': altered by its appearance within an aged body, but not tied to the ageing of that body.<sup>19</sup> We might say that, despite what is suggested by their names, Prichard's senile insanity was insanity *in* old age, while his senile dementia was insanity *of* old age.

Dementia, then, was the form of insanity most associated with ageing in this period. In his section on the relationship between insanity and age, Prichard repeated Esquirol's assertion that the various forms of madness could be tied to the life course: mania being characteristic of the young, melancholia of middle-age and dementia of the old.<sup>20</sup> However, though ageing was associated with dementia, dementia was not exclusively – nor even primarily – thought of as a disease of old age. In a table drawn from his practice at the Salpêtrière – again quoted by Prichard – Esquirol listed 21 different causes of dementia, from domestic grief, to blows to the head, to masturbation. Prichard inferred from this that '[t]he causes which produce [dementia] as an original disorder are nearly the same with those which in other cases excite madness [here, meaning other forms of insanity] in the first

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*English Court* (New Haven, 1995), pp. 76-80; Vieda Skultans, *English Madness: Ideas on Insanity, 1580-1890* (London, 1979), pp. 65-68.

<sup>18</sup> Prichard, *Treatise on Insanity*, p. 25.

<sup>19</sup> *Ibid.*, p. 25.

<sup>20</sup> *Ibid.*, p. 166.

instance'.<sup>21</sup> Unlike other forms of insanity, however, dementia was not always an 'original disorder' – the first form of insanity to appear as a result of the exciting cause – but was often a 'secondary affection', arising immediately subsequent to, and as a consequence of, another form of mental (or occasionally, bodily) disease. It was the state into which a long-term insane person might descend, when they no longer displayed acute or positive symptoms, but were clearly mentally wrecked by their insanity. This, Prichard implied, was the form of dementia most generally associated with the term: 'dementia...has been generally considered the result and sequel of [insanity]'.<sup>22</sup> Broadly speaking, dementia was a disease caused by a weakening or loss of energy – as will be discussed later – which could be brought on by the exhaustion of mental or physical strain, intoxication, another form of insanity or by the ageing process. Senility fit neatly into this aetiological framework but it did not, at this time, dominate it.

Prichard's *Treatise* was the authoritative text on insanity in Britain for at least 20 years following its publication, and thus Prichard's ideas about dementia – which were largely taken from Esquirol – came to be embedded in British psychiatry.<sup>23</sup> The influence of the section on dementia even outlived that of the *Treatise* overall. The textbook which usurped the *Treatise*'s authoritative position – John Charles Bucknill (1817-97) and Daniel Hack Tuke's (1827-95) *Manual of Psychological Medicine*, first published in 1858 – strayed little from Prichard's description in its discussion of dementia.<sup>24</sup> Tuke, who wrote all the chapters describing the different forms of insanity, did not present dementia primarily as a disease of ageing, but rather as a condition of the long-term insane: the examples he gave in the second, 1862, edition were almost all middle-aged women who had been insane since their youth.<sup>25</sup> He did, however, repeat Prichard's four-stage progression of dementia, thus committing to the progressive loss model of the

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<sup>21</sup> Ibid., pp. 85, 88.

<sup>22</sup> Ibid., pp. 6-7, 85.

<sup>23</sup> Andrew Scull, Charlotte MacKenzie and Nicholas Hervey, *Masters of Bedlam: the Transformation of the Mad-Doctoring Trade* (Princeton, 1996), p. 204.

<sup>24</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, pp. 121-30.

<sup>25</sup> John Charles Bucknill and Daniel Hack Tuke, *A Manual of Psychological Medicine* (2nd edn, London, 1862), pp. 116-20.



disease (with its resonances with ageing).<sup>26</sup> In his own section on the diagnosis of insanity, Bucknill reaffirmed that dementia should be understood as loss: 'In this form of disease, the mind [is] suffering from deprivation and not from aberration of function'.<sup>27</sup> Thus, through the *Manual*, the early nineteenth-century understanding and classification of dementia forged by Pinel, Esquirol and Prichard was consolidated rather than overturned. We can say, therefore, that, at least up until the 1860s, senility was *not* the prototype of dementia, but dementia was the prototype of mental senility. In 1874, when James Crichton Browne (1840-1938) described dementia as '[the] one kind of mental derangement which is properly specified by the adjective senile', he was drawing on this model of senility.<sup>28</sup> He was, however, somewhat out of step with many of his contemporaries. Though the close association between decay, disintegration, weakening, dementia and ageing did not disappear, a fresh classificatory paradigm was introduced in the 1860s which opened up new possibilities for the understanding of old-age mental disorder, and threatened to disrupt the seeming inevitability of the dementia/senility association.

### *David Skae and Somato-Aetiological Classifications*

The third edition of Bucknill and Tuke's *Manual*, published in 1874, contained a brand-new section, on 'The various forms of insanity from a somato-aetiological point of view'. Written by Tuke, this described forms of insanity which were defined by the bodily state or process from which they had sprung; from physical illnesses (febrile insanity), to reproductive phenomena (puerperal insanity, ovarian insanity), to physically intoxicating or exhausting activities (alcoholic insanity, masturbational insanity) or the life course (adolescent insanity, senile insanity).<sup>29</sup> This was a significant innovation. Twelve years previously, in the second edition, Tuke had expressed serious doubts that the 'insuperable difficulties' of forming an

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<sup>26</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, p. 124.

<sup>27</sup> *Ibid.*, p. 289.

<sup>28</sup> Michael Finn notes that Crichton Browne approved of Bucknill and Tuke's classificatory system: Finn, 'The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century', p. 99.

<sup>29</sup> John Charles Bucknill and Daniel Hack Tuke, *A Manual of Psychological Medicine* (3rd edn, London, 1874), pp. 318-92.

aetiologically based classification of insanity could ever be successfully overcome.<sup>30</sup> In the intervening period, however, a wave of aetiologically based classificatory systems swept across Europe.<sup>31</sup> This new commitment to aetiological and physiological classification had significant implications for the understanding of old-age mental disorder.

The life course featured heavily in these somato-aetiological classifications. In the absence of conclusive evidence as to the relationship between specific material changes and different forms of insanity, the stages of the life course provided easily identifiable – and hermeneutically rich – physical states, on which categories of insanity could be based. The social and medical stratification of the life course intensified in the nineteenth century. This made its way into theories of insanity, as a number of historians have shown. Sally Shuttleworth has suggested that ‘childhood’ insanity emerged as a possibility in the first half of the nineteenth century, after Esquirol and Prichard’s concepts of monomania moral mania allowed a person to be judged insane, regardless of their intellectual capacity.<sup>32</sup> Michael J. Clark has described the way that the older category of ‘masturbational’ insanity fed into a new category of ‘adolescent insanity’ in the second half of the nineteenth century, infusing that nascent life-course category with particular anxieties about purity and morbid introspection.<sup>33</sup> Hilary Marland has described the emergence, and subsequent disappearance, of ‘puerperal’ insanity in Victorian psychiatric literature.<sup>34</sup> Mid-nineteenth-century ideas about senile insanity should be set within this context: old age was just one area of the life course thought to involve particular physical and mental attributes. At the same time, strong pre-existent associations between old age and certain forms of mental deterioration made senile insanity one of the most prominent of these life-course-based forms of insanity.

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<sup>30</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, p. 81.

<sup>31</sup> Tuke referred specifically to the work of Dutch psychiatrist Jacob Schroeder Van der Kolk, and to French psychiatrist Augustin Morel. Bucknill and Tuke, *Manual of Psychological Medicine*, p. 401.

<sup>32</sup> Sally Shuttleworth, *The Mind of the Child: Child Development in Literature, Science and Medicine, 1840-1900* (Oxford, 2010), pp. 17-28.

<sup>33</sup> Michael J. Clark, 'Morbidity Introspection', *Unsoundness of Mind, and British Psychological Medicine, c. 1830 - c. 1900*, in W. F. Bynum, Roy Porter and Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry. Vol. 3* (London, 1988), pp. 85-90.

<sup>34</sup> Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke, 2004), pp. 9-27.

In Britain, David Skae (1814-73) was the seminal exponent of somato-aetiological classification. Skae was Medical Superintendent of Morningside Asylum in Edinburgh from 1846 until his death in 1873, during which time he also lectured to Edinburgh's medical students on mental disease. Historian Michael Barfoot has described Skae as a 'scientific general practitioner of insanity', who was committed to applying the empirical, inductive, scientific method of early nineteenth-century Edinburgh medicine to psychiatry.<sup>35</sup> This led him to reject the standard, symptomatically based classification of insanity, and to develop his own somato-aetiological scheme, based on the bodily conditions which gave rise to mental disorders. It was unacceptable to him that insanity – which was already broadly agreed to spring from dysfunction of the body and brain – was classified without reference to underlying physical conditions. For Skae, the physical disorder was the true disease, of which the mental symptoms were 'but the signs'. In an 1863 article in the *Journal of Mental Science*, he proposed a 'natural history' approach to insanity, employing the language of naturalism, in which 'varieties' of insanity were classified according to the 'natural order' of physical conditions to which they belonged, such as pregnancy or sunstroke. One of these orders was 'senile insanity'.

Although not explicitly recognised at the time, this classificatory change has significant implications for the understanding of both senility and dementia. It gave priority to physical states, as opposed to mental ones, in the classification of insanity. Thus, under Skae's scheme, the agedness of an old insane person's body became at least as relevant as their mental symptoms to the categorisation of their mental disorder. The symptomological categories of mania, melancholia and dementia did not disappear from Skae's system, but he used them to refer to transient mental conditions, rather than types of mental disease.<sup>36</sup> They were clinical categories, he suggested, but not truly medical ones. A person suffering from senile insanity might be in a state of mania one day, and dementia the next,

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<sup>35</sup> M. Barfoot., 'David Skae: Resident Asylum Physician; Scientific General Practitioner of Insanity', *Medical History*, 53 (2009), p. 470. See also Frank Fish, 'David Skae, M.D., F.R.C.S: Founder of the Edinburgh School of Psychiatry', *Medical History*, 9 (1965), pp. 36-53.

<sup>36</sup> Skae, 'A Rational and Practical Classification of Insanity', p. 309-19.

but the underlying reality of their disorder stayed the same: 'those changes which take place...after a certain period of life'.<sup>37</sup> Relegating terms like 'mania' and 'dementia' to the status of mere symptomatic description undermined their relationship to primary physical processes. This disrupted the close association between senility and dementia, though it did not destroy it entirely. It unloaded some of the physical connotations – the progressive physical degradation and overall weakening – from the now purely symptomatic category of 'dementia'. It also allowed terms such as 'senile mania' and 'senile melancholia' to be used to describe excitement and depression in (and of) old age.

Although Skae's particular classificatory system does not seem to have been adopted outside of Edinburgh, the influence of this somato-aetiological form of classification can be seen in many late-nineteenth-century psychiatric texts, particularly in the classification of the senile insanities. In the decades following the publication of Skae's 1863 article, and its extension in his posthumously published Morisonian lectures, 'senile insanity' was refracted in British psychiatric writings, and psychiatrists regularly referred to a multiplicity of senile disorders. This simultaneously opened up and closed down possibilities for the understanding of insanity in old age. On one hand, Skae's system suggested that insanity in old age could appear in myriad forms. Yet, on the other, whatever form this insanity took, it would always be 'senile', tied inextricably to the ageing process and the ageing body. Insane old people might be excited like a maniac, or depressed and deluded, but these symptoms could now all be interpreted as a sign of the same disorder: senile insanity. All signs of mental disorder in an old person could now be connected to their inevitable decay and decline. While Prichard's 'senile insanity' had not been insanity 'of' old age, then, Skae's certainly was.

Skae's ideas were spread through the enthusiastic advocacy of psychiatrists who had attended his clinical lectures at Morningside, and who had later found early employment under him as an assistant physician. Some of them, such as John Batty Tuke (1835-1913) and David Yellowlees (1850-1904), became influential

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<sup>37</sup> David Skae, 'The Morisonian Lectures on Insanity for 1873 - Lecture III', *Journal of Mental Science*, 20 (1874), pp. 12-13.

psychiatrists and important members of the Medico-Psychological Association in their own right. Crichton Browne, himself a former student at Edinburgh, referred to this group scathingly as 'the oecumenical council of Morningside', for their supposed dogmatic adherence to Skae's ideas.<sup>38</sup> This was somewhat unfair. Though great defenders of Skae, his former students adopted the spirit of somato-aetiological classification, rather than the particulars of Skae's classificatory scheme. Foremost among these former students was Thomas Clouston, who took over as the superintendent of Morningside after Skae's death in 1873, and compiled and edited his Morisonian lectures for publication.<sup>39</sup> Clouston's own textbook, *Clinical Lectures on Mental Diseases*, contained many life-course-based insanities: 'developmental insanities' (insanity of puberty and adolescence), 'insanities of decadence' (climacteric and senile insanities) and insanities relating to childbearing (puerperal insanity and insanities of pregnancy and lactation).<sup>40</sup> In the 1890s, Clouston contributed an entry on 'The Epochal Insanities' to the monumental, encyclopaedic *System of Medicine*. There, he explained that the 'mental and bodily symptoms and accompaniments [of insanity] are influenced in such a way at each epoch that the cases have certain common characteristics, and may properly be classified accordingly'.<sup>41</sup> For Clouston, then, the stage of life in which an attack of insanity appeared was often essential to its character. He did not think, however, that the influence of the life course on insanity was uniform. In his *Clinical Lectures*, Clouston declared himself 'quite astonished at the immense variety of symptoms' presented in cases of senile insanity.<sup>42</sup> He suggested that senile insanity, perhaps

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<sup>38</sup> J. Crichton Browne, 'Skae's Classification of Mental Diseases: A Critique', *The British Journal of Psychiatry*, 21 (1875), p. 339.

<sup>39</sup> Allan Beveridge, 'Thomas Clouston and the Edinburgh School of Psychiatry', in G. E. Berrios and H. L. Freeman (eds), *150 Years British Psychiatry* (London, 1991), p. 365; David Skae, 'The Morisonian Lectures on Insanity for 1873', *Journal of Mental Science*, 19 (1873), pp. 340-55; David Skae, 'The Morisonian Lectures on Insanity for 1873', 21 (1875), pp. 1-18, 118-207.

<sup>40</sup> Clouston, *Clinical Lectures on Mental Diseases*.

<sup>41</sup> T. S. Clouston, 'The Epochal Insanities', in Thomas Clifford Allbutt (ed.), *A System of Medicine: by many writers. Vol. 8* (London, 1899), p. 295.

<sup>42</sup> Clouston, *Clinical Lectures on Mental Diseases*, p. 578.

even more so than other forms of epochal insanity, could appear in a variety of forms: senile mania, melancholia and dementia.<sup>43</sup>

The influence of these somato-aetiological classifications spread from Edinburgh to the rest of British psychiatry. In 1876, Clouston led the charge at the MPA for an officially recognised nomenclature of insanities to be used in their statistical tables.<sup>44</sup> The eventual result, published in 1882, did not fully express Skae's somato-aetiological approach, but it appears to respond to his criticisms of the traditional symptomalogical categories as insufficient in themselves to describe disease entities. In this classificatory scheme, mania, melancholia and dementia were still the main diagnostic categories, but they were split into smaller sub-categories, relating to duration, intensity, and cause. Though few aetiological categories were included, 'senile' appears as a sub-category under all three of the larger headings.<sup>45</sup> In this classification, senile mania and melancholia are offered as much legitimacy as senile dementia. The refraction of senility, then, was one of the more enduring legacies of Skae's work.

Although Clouston broadly agreed with Skae, that 'dementia' was more a clinical condition than an underlying disorder, his overall understanding of dementia was quite conventional. He described it as a mental enfeeblement brought on by the exhaustion of disease, shock, overwork, intoxication or age. Exhaustion was the central element of Clouston's understanding of dementia and thus he considered secondary dementia – resulting from acute mental illness – to be its essential type:

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<sup>43</sup> Clouston, *Clinical Lectures on Mental Diseases*, pp. 564-90; Clouston, 'The Epochal Insanities', pp.304-7.

<sup>44</sup> 'Annual General Meeting of the Medico-Psychological Association', *Journal of Mental Science*, 22 (1876), pp. 492-93. See also pp. 203-4.

<sup>45</sup> 'Report of the Thirty-Seventh Annual Meeting of the Medico-Psychological Association', *Journal of Mental Science*, 28 (1882), p. 460. See Appendix 1.

It is the most characteristic, the most common, and the most important of all the kinds of mental enfeeblement, so that when you hear of a person labouring under dementia, it is usually this that is meant. It is dementia *par excellence* therefore [emphasis his].<sup>46</sup>

For Clouston, then, *secondary* dementia was the 'prototype of dementia' – 'dementia *par excellence*' is his term – and he confidently suggested that this notion was widely shared. Having said this, the categories of dementia and senility were not entirely separated in Clouston's work. Though he made it very clear that he believed that senile insanity presented in an 'immense variety' of forms, he conceded that 'there is no doubt that [the] pure type [of senile insanity] is to be found in...senile dementia'.<sup>47</sup> It seems, then, that even as a multiplicity of senile insanities were appearing in the literature of psychiatry, the association between the mental disintegration of dementia and ageing remained strong.

In 1889, William Bevan Lewis, chided medical students for being 'too apt to assume that all varieties of mental ailments in the aged issue in senile dementia'. By the 1880s, then, the term 'senile insanity' no longer referred to a specific type of moral insanity; it had become an umbrella term, encompassing all the varieties of senile mental disorder. According to Bevan Lewis, senile insanity 'embrac[ed]...all the forms of insanity usually delineated'.<sup>48</sup> The book in which these statements appeared, *A Text-book of Mental Diseases*, was praised by members of Skae's 'oecumenical council'.<sup>49</sup> Yet Bevan Lewis was not himself a product of Morningside. His intellectual lineage was rooted in another school of thought in British psychiatry, one which formulated yet another way of looking at insanity, and which significantly reinforced the relationship between dementia and senility. This, too, can be traced back to mid-century Edinburgh.

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<sup>46</sup> Clouston, *Clinical Lectures on Mental Diseases*, p. 271.

<sup>47</sup> Ibid., p. 578.

<sup>48</sup> Bevan Lewis, *A Text-Book of Mental Diseases*, pp. 405-6.

<sup>49</sup> Tuke, 'A Plea For The Scientific Study Of Insanity', p. 1161.

### *Dissolution, Dementia and Senility*

The development of the theory of dissolution, by neurologist, John Hughlings Jackson, in the 1870s, provides the second chronological turning point in this narrative. The roots of this theory, however, go back to the 1850s. In 1855, having previously taught at the York Medical School, Thomas Laycock (1812-76) was recruited to a professorship at Edinburgh. Though never an asylum Superintendent, he became one of the most influential figures of mid-century British psychiatry through his teaching and writing. He lectured at York and at Edinburgh on medical psychology and mental pathology. Many students at Edinburgh received instruction from both Laycock and Skae, including Thomas Clouston.<sup>50</sup> Laycock's former students described him in reverential terms; James Crichton Browne famously called him 'a biological Socrates'.<sup>51</sup> While Skae was first and foremost a clinician, who sought to influence the practice of clinical psychiatry in a very practical way, Laycock's contribution to psychiatric knowledge was more theoretical, as a pioneer of physiological psychology.<sup>52</sup> Though medically trained, his major publications were more concerned with the relationship between the mind and body than the practice of medicine. He was interested primarily in the structure and function of the nervous system, and its relationship to human (and animal) psychology. From early on in his career, Laycock was an exponent of the reflexive, sensory-motor theory of nervous function and mental activity. This theory had developed from a number of pioneering neuro-physiological experiments on animals which took place across the continent in the first three decades of the nineteenth century. These experiments produced similar findings regarding the structure of the nervous system, from which a broadly agreed theory of the nervous system emerged. Neuro-physiologists, such as Marshall Hall, suggested that the nervous system was made up of pairs of nerves, one 'sensory'

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<sup>50</sup> J. M. López Piñero, 'The Work of John Hughlings Jackson: Part 1', *History of Psychiatry*, 21 (2010), p. 90; Beveridge, 'Thomas Clouston and the Edinburgh School of Psychiatry', pp. 371-72.

<sup>51</sup> Finn, 'The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century', p. 50.

<sup>52</sup> Allen Beveridge suggests that there was a minor professional rivalry between the two, although they worked quite separately. Beveridge, 'Thomas Clouston and the Edinburgh School of Psychiatry', p. 372.



and one 'motor'. Bodily activity could be understood through the joint activity of these paired nerves: the stimulation of the former led to a response in the latter. Physical movement, then, was understood as a product of automatic, physiologically produced, reflexes.<sup>53</sup>

Most early exponents of this theory stopped short of applying the reflexive response theory to the brain, and thus to the processes of mind.<sup>54</sup> Laycock was not so cautious. In an article published in 1844, 'On the reflex function of the brain', Laycock argued that the brain was composed of the same structural components as the rest of the nervous system, and was similarly governed by sensation and motion. Thus, thought, emotion, and consciousness itself was the product of automatic reflex processes. Laycock maintained that reflex actions governed *all* mental activity, not just the lower 'instincts'. Under this framework, all mental activity was brought into one continuous hierarchy. Human consciousness was not unique, but simply an elaboration of the same nervous processes which governed the activity of animals. As he wrote in 1844,

The law of the unity of type and function in animals, applied ...  
to the function of the cerebro-spinal axis in man, has shown ...  
that the transmission of structure and function is gradual, and  
consequently no strong line of demarcation can be drawn  
between the manifestations of its various functions. The  
automatic act passes insensibly into the reflex, the reflex into  
the instinctive, the instinctive are quasi emotional, the  
emotional intellectual.<sup>55</sup>

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<sup>53</sup> The foundational work in this area was done by Charles Bell and Francois Magendie in the early-nineteenth century, who separately discovered that nerves performed either the receptive function of sensing, or the active function of moving (the Bell-Magendie law). This was developed into a theory of nervous functioning by British neurologist Marshall Hall in the 1830s and 40s. Edwin Clarke and L. S. Jacyna, *Nineteenth-Century Origins of Neuroscientific Concepts* (Berkeley, 1987), pp. 101-56.

<sup>54</sup> L. S. Jacyna, 'The Physiology of Mind, the Unity of Nature, and the Moral Order in Victorian Thought', *The British Journal for the History of Science*, 14 (1981), p. 111-12.

<sup>55</sup> As quoted in Robert M. Young, *Mind, Brain, and Adaptation in the Nineteenth Century: Cerebral Localization and its Biological Context from Gall to Ferrier* (New York, 1990), p. 204.

The four stages of nervous activity outlined here resemble a reversal of the stages of disintegration in dementia outlined in Prichard's *Textbook*, published only ten years earlier: from intellect, to instinct, to simple organic automation. Laycock's hierarchy was, however, more decisively embodied than Prichard's. While Prichard had implied that physical phenomena underlay mental disintegration in some way, Laycock's belief in a continuous chain of sensory-motor structures and processes offered a precise physiological explanation of this relationship. Laycock's theory implied that a disintegration of mind was an expression of the physiological disintegration of the nervous hierarchy, which also constituted a descent – mentally and physiologically – down the evolutionary scale. This association between mental, physical and evolutionary disintegration had significant implications for the understanding of both dementia and ageing.

This idea was developed and extended in the work of another of Laycock's erstwhile students, John Hughlings Jackson. Hughlings Jackson encountered Laycock at the very beginning of his medical career, attending Laycock's medical lectures whilst undertaking a medical apprenticeship in York.<sup>56</sup> He then moved to London, where he completed his training and spent the majority of his career, devoted mainly to treating and researching nervous diseases from both a clinical and neuro-anatomical perspective. He had strong connections with the neurological research at the West Riding Asylum, and was a cofounder of the journal *Brain*. He has been credited with bringing order to the chaos of late-nineteenth-century neurological knowledge, and his influence on modern neuroscience has been expressed by historians in the strongest of terms: a 1998 biography calls him the *Father of English Neurology*. Like Laycock, he was not a psychiatrist, and never held a post at an asylum, but his work had a profound impact on the understanding of insanity in the late-nineteenth century, particularly on the understanding of dementia.<sup>57</sup>

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<sup>56</sup> Hansruedi Isler, 'Laycock as the Source of Hughlings Jackson's Reflex and Evolutionary Theories', in F. Clifford Rose (ed.), *A Short History of Neurology: the British Contribution, 1660-1910* (Oxford, 1999), p. 147.

<sup>57</sup> For biographical detail of Hughlings Jackson's life and work, see Macdonald Critchley and Eileen A. Critchley, *John Hughlings Jackson: Father of English Neurology* (Oxford, 1998); C. U. M. Smith,

Besides Laycock, Herbert Spencer was the other great influence on Jackson's thinking.<sup>58</sup> A true Victorian polymath, Spencer's prolific writings touched on psychology, philosophy, sociology and biology. These disparate works were united by his understanding of a universally applicable principle of evolution. He was not as concerned as Darwin with why and how evolution occurred, but rather with the manner in which it occurred: as a change from the homogenous to the heterogeneous, from the simple to the complex.<sup>59</sup> This law, according to Spencer, governed development in all arenas of life, from organic matter, to societies, to languages. Hughlings Jackson applied it to the nervous system. He interpreted Laycock's nervous hierarchy as a sequence of increasingly complex levels of neurological organisation:

[E]volution is a passage from the most to the least organised, that is from the lowest, well organised centres, to the highest, least organised, centres; putting this otherwise, the progress is from centres comparatively well organised at birth up to those, the highest centre, which are continually organising throughout life.<sup>60</sup>

More complex nervous layers were associated with the most sophisticated forms of mentation. These could be expected to develop later in a species' evolutionary

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'Evolution and the Problem of Mind: Part II. John Hughlings Jackson', *Journal of the History of Biology*, 15 (1982); López Piñero, 'The Work of Hughlings Jackson: Part 1' pp. 85-95, J. M. López Piñero, 'The Work of John Hughlings Jackson: Part 2', *History of Psychiatry*, 21 (2010), pp. 224-36. Discussions of his work can also be found in Young, *Mind, Brain and Adaptation*, pp. 197-223; Anne Harrington, *Medicine, Mind, and the Double Brain: a Study in Nineteenth-Century Thought* (Princeton, 1987), pp. 206-34.

<sup>58</sup> Discussion of Spencer's influence is included in all accounts of Hughlings Jackson's work, but see particularly Young, *Mind, Brain and Adaptation*, pp. 197-204; C. U. M. Smith, 'Evolution and the Problem of Mind: Part I. Herbert Spencer', *Journal of the History of Biology*, 15 (1982), pp. 55-88; Smith, 'Evolution and the Problem of Mind: Part II. John Hughlings Jackson', pp. 241-62.

<sup>59</sup> Spencer repeated and elaborated on his principle of evolution throughout his career, but one of the earliest, and clearest, descriptions of it can be found in Herbert Spencer, 'Progress: Its law and cause', *Westminster Review*, 67 (1857), pp. 445-47. Hanreudi Isler has argued that Jackson first encountered this version of evolution – progress from homogeneity to heterogeneity – from Laycock, who took it from the pre-Spencer works of German morphologists, particularly Ernst von Baer. Isler, 'Laycock as the Source of Hughlings Jackson's Reflex and Evolutionary Theories', pp. 145-50.

<sup>60</sup> John Hughlings Jackson, 'Evolution and Dissolution of the Nervous System', in J. Taylor (ed.), *Selected writings of John Hughlings Jackson: vol. 2* (London, 1958), p. 46.

development, and later in the individual life. James Crichton Browne, a friend and colleague of Hughlings Jackson, took up this idea enthusiastically. In an article 'On Old Age', published in 1891, Crichton Browne suggested – drawing also on the work of Wakefield neurologist, David Ferrier, among others – that the frontal lobes of the human brain were the most recent and most sophisticated product of man's evolutionary development, and as such were the last part of the body to reach full maturity. They would, in fact, not reach their fullest perfection until late-middle age. Being the most sophisticated parts of the brain, they were responsible for the highest mental faculties. This being the case, 'judgment and reason...come to their perfection... in all likelihood between the 55th and 65th years, and may be exercised justly till an advanced age'.<sup>61</sup> Writing at the age of 51, Crichton Browne had decided that his best years were still ahead of him.

Although it gave rise to this optimistic assessment of ageing, the evolutionary understanding of the nervous system mostly produced much more pessimistic descriptions of the ageing process. In the 1880s, Jackson adopted another idea from Herbert Spencer's organic philosophy, which he had named 'dissolution'. This, according to Spencer, was evolution in reverse: a process of decomposition from the most to the least complicated.<sup>62</sup> It formed a small part of Spencer's largely optimistic *oeuvre*, but it became central to late-nineteenth-century psychiatry, after Hughlings Jackson used it to build his own theory of insanity. Insanity, he suggested, was itself a process of dissolution, whereby the more complicated and highly evolved layers of nervous organisation were removed, thus demoting the sufferer to a lower level of evolutionary development and mental functioning. Higher layers of the nervous system performed two roles: producing the higher mental functions and capacities, such as reason and morality, and also restraining the activity of the lower, less evolved layers. Because they were products of an earlier stage of development, the lower layers were incapable of adapting successfully to external conditions, so the thoughts and behaviour they produced

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<sup>61</sup> James Crichton Browne, 'On Old Age', *The British Medical Journal*, 2 (1891), p. 732.

<sup>62</sup> Dissolution was not a central idea in Spencer's work, but it was first mentioned in Herbert Spencer, *First Principles* (London, 1862), p. 486. He developed the idea more fully in the second edition (1867), ch. 23.

were incoherent and bizarre. In insanity, higher layers of the nervous system were damaged or rendered inactive, leading to a loss of mental function, described by Hughlings Jackson as the 'negative symptoms'. The insane person was therefore functioning through the operation of lower, less well-adapted layers, which had been left uncontrolled, producing 'positive symptoms' (such as 'illusions, hallucinations, delusions, and extravagant conduct').<sup>63</sup> The lunatic was a simple, de-evolved person, unable to comprehend or adapt to a complex, rapidly progressing world.<sup>64</sup>

Hughlings Jackson himself declared that his principle of dissolution was 'of little use for [the] direct practical purposes' of asylum classification.<sup>65</sup> In spite of this disclaimer, the idea of dissolution was taken up enthusiastically by a number of psychiatrists at the end of the nineteenth century, and worked into classificatory schema and textbooks which were written in and for a clinical context.<sup>66</sup> In these works, the old category of dementia became strongly identified with the new concept of dissolution. Dementia, after all, was the existent clinical term used to describe a process of mental loss and disintegration. In the clinically oriented works inspired by Hughlings Jackson, dementia was re-imagined as an expression of dissolution in its broadest and simplest form.

Some psychiatrists began to use the terms 'dementia' and 'dissolution' interchangeably. This conflation was particularly evident in the work of Charles Mercier (1852-1919), a London-based asylum physician and lecturer in mental diseases, who had been taught by Hughlings Jackson at the London Hospital in the early 1870s.<sup>67</sup> In his 1902 *Textbook of Insanity*, he wrote that:

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<sup>63</sup> Hughlings Jackson, 'Evolution and Dissolution', p. 46.

<sup>64</sup> John Hughlings Jackson, 'The Factors of Insanities', *The Medical Press and Circular*, 108 (1894), pp. 18-22.

<sup>65</sup> As quoted in Kenneth Dewhurst, *Hughlings Jackson on Psychiatry* (Oxford, 1982), p. 104.

<sup>66</sup> Bevan Lewis, *A Text-Book of Mental Diseases*; Charles Arthur Mercier, *Sanity and Insanity* (London, 1895); Joseph Shaw Bolton, 'Amentia and Dementia: A Clinico-Pathological Study', *Journal of Mental Science*, 51-58 (1905-8); W. H. B. Stoddart, *Mind and its Disorders: A Text-Book for Students and Practitioners* (London, 1908).

<sup>67</sup> 'Charles Arthur Mercier, M.D.Lond., F.R.C.P., F.R.C.S., Consulting Physician For Mental Diseases, Charing Cross Hospital; Past President Of The Medico-Psychological Association', *The British Medical Journal*, 2 (1919), pp. 363-65.

In all cases of insanity, the real and important aberration is...  
the degradation of activity to a lower plane; and it is this  
degradation that is indicated by the term dementia.<sup>68</sup>

In Mercier's work, then, dementia was synonymous with the 'negative' part of dissolution: the term dementia was used to describe loss of function, while other terms – such as mania and melancholia – were used to describe insanities which produced 'positive' symptoms. Thus, for Mercier, as for all those who preceded him, dementia was characterised by progressive loss and mental weakness. However, by conflating it with the neuro-physiological process of dissolution, Mercier added a concretely material element to the concept of dementia. No longer a mere collection of symptoms, the theory of dissolution reified dementia as a patho-physiological entity, tied to a straightforward material process, with a predictable progression.

Dissolution was also closely identified with the physiological process of 'natural' ageing. We can see this in the work of one of Mercier's contemporaries, William Bevan Lewis. Though educated at Guy's Hospital in the 1860s, Bevan Lewis was really a product of Crichton Browne's neuro-clinical research school at Wakefield, where he arrived as a clinical assistant in 1875, rising to the position of Medical Superintendent in 1884.<sup>69</sup> His *Textbook of Mental Diseases* can be seen as the most thorough-going attempt to apply Hughlings Jackson's insights – psychological and neurological – to clinical psychiatry. For Bevan Lewis, all insanity was caused by local dissolutions. The precise nature of the insanity would depend on its neurological location. Only in 'senescence', he suggested, would dissolution occur in a uniform way across the whole nervous system, retracing the steps of psycho-physiological development in their exact reverse order, 'so that the mental wave recedes along the whole line of its former advance'.<sup>70</sup> Here, he was equating dissolution with a natural process of ageing, inevitable at the end of a long life. In the opening to his chapter on senile insanity, Bevan Lewis reminded students to

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<sup>68</sup> Charles Mercier, *A Text-book of Insanity* (London, 1902), p. 113.

<sup>69</sup> 'William Bevan-Lewis, M.Sc., M.R.C.S., L.R.C.P', *Journal of Mental Science*, 76 (1930), pp. 383-88.

<sup>70</sup> Bevan Lewis, *A Text-Book of Mental Diseases*, p. 176.

keep in mind the diversity of insanities which could arise in old age, and not to assume that senile insanity – for him, the pathological exaggeration of physiological senility – always assumed the form of dementia. However, the resonance between the processes of ageing, dissolution and dementia were inescapable, and the development of the theory of dissolution encouraged the marginalisation of all other forms of senile insanity. Thus, even Bevan Lewis proved unable to heed his own warnings. In the discussion which follows his opening section on senile insanity, quoted at the beginning of this chapter, the boundary between the various forms breaks down, and he uses the terms ‘senile insanity’ and ‘senile dementia’ interchangeably.<sup>71</sup> Both, he suggested, represented dissolution in its purest form:

The decay of the intellectual is followed by failure of the sentient element of mind; emotion and feeling become slowly impaired, but at a much later date. Still, the patient may pursue his usual course of life, and all deeply-rooted sympathies, weaknesses, and prejudices may prevail in full force; the customary habits of a long life maintain their ascendancy; and though special aptitudes fail, the more general are still retained. Eventually, with their decline the subject is reduced to a mere vegetative state of existence. The whole process forcibly illustrates the law of dissolution, whereby the most-specialised, most-complex, and least-organised nervous arrangements suffer first, and the more-general, least-complex, and more-organised and stable nervous-arrangements are the last to succumb; in other words, the dissolution takes the course from the least to the most stable arrangements.<sup>72</sup>

This map for the progression of dementia is remarkably similar to the one set out by Prichard, over 50 years before: a reversion from a state of intellect and will, to a state of habit, to a state of ‘mere vegetative...existence’. However, Bevan Lewis’ version of mental disintegration is underpinned by a new set of concepts and

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<sup>71</sup> Bevan Lewis, *A Text-Book of Mental Diseases*, pp. 405-34.

<sup>72</sup> *Ibid.*, pp. 433-34.

phrases, here expressed in unequivocally Spencerian terms: a reversion from 'the least to the most stable arrangements'. Dissolution offered a new language with which to explain a long-recognised phenomenon, and reinforced the deeply embedded association between ageing, dementia, and progressive disintegration.

The principle of dissolution, then, was aligned to both ageing and dementia, reinforcing the pre-existent connection between the two. Charles Mercier took this connection the furthest, and explicitly conflated the processes of ageing, dementia, and dissolution. For him, the relationship between ageing and dementia was unequivocal. Unlike Prichard, he was prepared to state categorically that dementia was inevitable in old age. Senile dementia was infrequently seen, he suggested, because 'real old age' was itself infrequently reached. In most people, the 'candle of life is blown out or extinguished', before they reach their natural end. Those who outlived accident or disease, however, would find themselves eventually subject to 'natural decay'.<sup>73</sup> For Mercier, the mental degeneration of old age was not a form of insanity. It was a straightforward physiological process, like sleep or intoxication, which led to an altered mental state. Nevertheless, he named this phenomenon 'dementia' and described it in dissolutionary terms:

From beginning to end the process is a continuous, gradually progressing loss... affecting, first and most, the highest faculties, and leaving till the last those that are simplest, lowest, and most fundamental. The decadence of old age is, in fact, a *dementia*, a deprivation of mind.<sup>74</sup>

As this statement makes clear, Mercier thought that ageing and dementia were the same thing: a dissolution of the nervous system, from the highest structures, to the lowest. For Mercier, then, dementia was more than just the prototype of senility; dementia was senility.

Although the relationship between dementia and ageing was being described in such strong terms, other forms of dementia did not disappear from

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<sup>73</sup> Mercier, *Sanity and Insanity*, pp. 306-7.

<sup>74</sup> *Ibid.*, p. 310.



psychiatric writings. Primary and secondary dementia remained as forms of insanity in classificatory schema into the twentieth century. During this period, however, these non-senile dementias were described as an early expression of the mental degeneration of old age, brought on prematurely by external factors. Throughout the nineteenth century, all different forms of dementia were united in their aetiology: an event or circumstance which exhausted the mind and body. Senile dementia was no different; it was viewed as a consequence of the exhaustion of living for a long time. At the end of the century, however, ageing came to the fore, as the ultimate expression of this exhaustion. Mercier, for example, stated in 1890, that dementias at all ages were brought about by 'a failure of energy, which is due to occur at the end of life, [and which] sets in prematurely'.<sup>75</sup>

Joseph Shaw Bolton (1867-1946), a pathologist at the Claybury Asylum in London, who later succeeded Bevan Lewis at Wakefield, put this principle at the centre of his own classificatory system of insanity.<sup>76</sup> As Bevan Lewis had done in his *Textbook*, Bolton sought to produce a grand synthesis of his clinical and neurological knowledge. In a series of articles published between 1905 and 1908, he set out a new psycho-pathological classificatory system, based on a large-scale empirical study of asylum patients and their brains.<sup>77</sup> This system contained two overarching categories: amentia and dementia. In Bolton's classification, all insanities which were not congenital were classified as a form of 'dementia'. These dementias, he wrote, were all 'examples of natural involution of the cortical neurones, which occurs in the reverse order to that of their evolution'.<sup>78</sup> This word 'involution' – when used in this sense – originated in the work of the German *Naturphilosophes*, in the first half of the nineteenth century. In this intellectual tradition, the word '*Entwicklung*' (also described as '*evolutio*' in German works and

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<sup>75</sup> See pp. 75-86.

<sup>76</sup> J. Ivison Russell, 'Joseph Shaw Bolton', *Journal of Mental Science*, 93 (1947), pp. 481-82.

<sup>77</sup> Joseph Shaw Bolton, 'Amentia and Dementia: A Clinico-Pathological Study', *Journal of Mental Science*, 51, (1905), pp. 270-340, 507-39, 639-76; Joseph Shaw Bolton, 'Amentia and Dementia: A Clinico-Pathological Study', *Journal of Mental Science*, 52 (1906), 1-28, 221-40, 427-90, 711-44, Joseph Shaw Bolton, 'Amentia and Dementia: A Clinico-Pathological Study', *Journal of Mental Science*, 53 (1907), pp. 84-121, 423-74; Joseph Shaw Bolton, 'Amentia and Dementia: A Clinico-Pathological Study', *Journal of Mental Science*, 54 (1908), pp. 433-72.

<sup>78</sup> Bolton, 'Amentia and Dementia: a Clinico-Pathological Study', *Journal of Mental Science*, 52 (1906), p. 429.

translated as 'evolution' in English) was used to describe both embryonic development and growth, and the evolutionary development of the species.<sup>79</sup> In 1839, German physician, Karl Friedrich Canstatt, used the word 'involution', in his book *Die Krankheiten des höheren Alters und ihre Heilung* ('The Illnesses of Old Age and their Treatment') to describe the opposite process. In this book, 'involution' means 'ageing', but it is imbued with the same associations embedded in '*Entwicklung*'.<sup>80</sup> As a contemporary English physician put it, '[Canstatt's] "involution-period" is characterised, physiologically, by a return of the organism to the commencement of the evolution-period'.<sup>81</sup> For Canstatt, then, ageing was itself a dissolutionary unmaking of a person, from their latest to earliest stages of development, evolutionarily and individually speaking. This idea shared an intellectual lineage with Hughlings Jackson's theory of dissolution, and was entirely compatible with it. The word 'involution' entered British psychiatry in the early 1890s, carrying with it these dual meanings of ageing and de-evolution.<sup>82</sup> Thus, when Bolton described dementias as 'examples of natural involution', he was suggesting that *all* dementias were enactments of the ageing process, as well as a de-evolutionary dissolution. Dementia at a younger age occurred when 'extraneous causes', or inborn weakness, brought on this 'natural involution' prematurely.<sup>83</sup> For Bolton, then, all dementias were essentially senile dementia.

This is the manner in which, in Berrios' terms, senile dementia became the 'prototype of dementia'. Theories of evolution and dissolution provided a unified framework, and a material basis, through which ageing and dementia could both be described and explained. Through these theories, dementia came to be understood as an enactment – sometimes premature – of the natural process of ageing. Consequently, the way in which insanity in old age was categorised and described was limited. This is demonstrated in the updated classification published by the

<sup>79</sup> Peter J. Bowler, 'The Changing Meaning of "Evolution"', *Journal of the History of Ideas*, 36 (1975), pp. 99-100.

<sup>80</sup> Karl Friedrich Canstatt, *Die Krankheiten des höheren Alters und ihre Heilung* (Erlangen, 1839), pp. iii-vi.

<sup>81</sup> Daniel Maclachlan, *A Practical Treatise on the Diseases and Infirmitities of Advanced Life* (London, 1863), pp. 3-4.

<sup>82</sup> Crichton Browne, 'On Old Age', p. 731; Tuke, 'A Plea For The Scientific Study Of Insanity', p. 1162.

<sup>83</sup> Bolton, 'Amentia and Dementia', p. 429.

MPA in 1906. This was drawn up to replace the classification published in 1882. The different ways in which 'senile' categories are featured in these two classifications illustrate the narrative of change described in this chapter. In 1882, there are three types of insanity: senile mania, melancholia and dementia. In 1906, only senile dementia remains. The conceptual identity of ageing and dementia, underlined by the theory of dissolution, had thus overwhelmed the multiplicity of senile insanities encouraged by somato-aetiological classification. Dementia had taken on a more material meaning, as a process of structural disintegration, which confirmed its identity as the only form of insanity which was also an expression of the decay of ageing. There are still other dementias in the 1906 classification: primary and secondary. However, as shown in the discussions of Mercier and Bolton above, these dementias were now largely interpreted as a premature enactment of the ageing process. There had always been significant resonances between the categories of senility and dementia, but by the early twentieth century, they had become inextricably intertwined.

### **The Symptoms of Dementia and the 'Cognitive Paradigm'**

The second thematic section of this chapter will consider specifically the category of dementia, and the symptoms ascribed to it. The changing symptomatic paradigm of dementia has been of particular interest to historian-clinician, German Berrios. He has argued that the late-nineteenth century saw a

narrowing down of the clinical scope of "dementia" ... [which] culminated in the early 1900s with the consolidation of the "cognitive paradigm" i.e. the view that dementia consisted of an irreversible disorder of the intellectual functions.<sup>84</sup>

This section will trace the emergence of the 'cognitive paradigm' in British psychiatry, but will add an interpretive layer to Berrios' narrative of symptomatic

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<sup>84</sup> Berrios, 'Dementia', p. 34. See also Berrios, 'Memory and the Cognitive Paradigm of Dementia'; G. E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century* (Cambridge, 1996), pp. 199-200.

'attrition'.<sup>85</sup> It will mobilise John Hughlings Jackson's concepts of 'negative' and 'positive' symptoms: negative symptoms being those which involve a loss of mental functions, such as reason, memory or feeling; and positive symptoms being those which involve the production of a new behaviour, activity, mood, or idea, such as depression, excitement, delusion or hallucination. This section will argue that a negative symptomatic paradigm was embedded in the concept of dementia from at least the mid-nineteenth century, but that it encompassed more than just the loss of cognitive functions. Dementia was viewed as a slowing, weakening, and eventual obliteration of the mind in its entirety; 'a gradually increasing decay of mind until there is nothing left that we properly call mind', as Henry Maudsley (1835-1918) put it.<sup>86</sup> No mental faculty would escape this obliteration. Thus, emotional change was also brought into the negative symptomatic paradigm of dementia. Up until the 1880s, this section will argue, the primary losses of dementia were thought to involve the powers of sensation, attention and perception. From these losses, it was thought, all other losses of dementia – of memory, of reason, of moral feeling – could be accounted for. However, two intellectual developments at the end of the nineteenth century shifted the emphasis from a loss of sensation to a loss of reason. These were the adoption of the theory of dissolution, and the acceptance of cerebral localisation. It was largely through the influence of these late-nineteenth-century ideas that the 'cognitive paradigm' of dementia emerged.

The attrition of the symptomatic paradigm of dementia, and its restriction to negative symptoms, can be seen clearly in successive editions of Bucknill and Tuke's *Manual of Psychological Medicine*. In the first edition, published in 1858, Tuke quoted two different descriptions of dementia: one written by Philippe Pinel in 1801, the other written some years later by Jean-Etienne Esquirol. Pinel's definition was quite broad:

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<sup>85</sup> Berrios, 'Dementia', p. 46.

<sup>86</sup> Henry Maudsley, *Responsibility in Mental Disease* (3rd edn, London, 1876), p. 256.

[Dementia consists of] rapid succession or uninterrupted alternation of insulated ideas, and evanescent and unconnected emotions; continually repeated acts of extravagance; complete forgetfulness of every previous state; diminished sensibility to external impressions; abolition of the faculty of judgement; perpetual activity.<sup>87</sup>

This definition contains negative symptoms ('forgetfulness'; 'diminished sensibility'; 'abolition of...judgement') and positive ones ('rapid succession...of ideas'; 'evanescent...emotions'; 'acts of extravagance'; 'perpetual activity').

Esquirol's definition was far more limited:

There exists... a form of mental alienation which is very distinct — in which the disorder of the ideas, affections, and determinations, is characterised by feebleness, and by the abolition, more or less marked, of all the sensitive, intellectual, and voluntary faculties. This is dementia.<sup>88</sup>

Esquirol had thus jettisoned the positive symptoms attached to dementia by Pinel. This was a move strongly endorsed by Tuke. He suggested that some of the symptoms in Pinel's definition – the acts of extravagance and excitement – might be more appropriately categorised as signs of mania. For Tuke, such outbursts in a generally demented patient should be considered 'maniacal': only the abolition of the faculties constituted dementia.<sup>89</sup> In the second edition of the *Manual*, published in 1862, Pinel's definition of dementia, along with any mention of positive symptoms, was removed altogether.<sup>90</sup> The purely negative paradigm of dementia, which can be traced back to Esquirol, and was endorsed and enhanced by the *Manual*, supplied the contours of the psycho-pathological description of dementia for the rest of the century. Throughout the nineteenth century, the dement was presented as a person who had been hollowed out, stripped of their mental faculties

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<sup>87</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, p. 121.

<sup>88</sup> *Ibid.*, p. 122.

<sup>89</sup> *Ibid.*, p. 123.

<sup>90</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, (2nd edn, 1862), pp. 113-14.

one by one. In 1884, George Savage (1842-1921) compared the dement to an abandoned, ruined house, whose four walls still stood, but whose interior was entirely empty.<sup>91</sup>

*Sensation, attention and memory*

Esquirol, then, can be seen as the source of the negative symptomatic paradigm of dementia in nineteenth-century British psychiatry. Prichard, in his description of the symptomatic paradigm of dementia, quoted Esquirol at length:

Dementia...deprives men of the faculty of adequately perceiving objects, of seeing their relations, of comparing them, of preserving a complete recollection of them; whence results the impossibility of reasoning.<sup>92</sup>

For Esquirol, the failure of reasoning was secondary to one of perception. Dements, he said, could neither create nor retain an accurate picture of the world around them. This loss of the faculty of perception arose, he suggested, from three different systemic failures: a failure of sensation, a loss of energy in the 'organs of transmission' which transferred these sensations to the brain, and a weakening in the brain itself, which no longer had 'sufficient strength to receive and retain the impression which is transmitted to it'. The demented failure of perception was thus primarily viewed as a physiological failure. The parts of the body responsible for ushering ideas from the external world into the mind had lost the energy necessary for them to perform that task efficiently. For Esquirol, it was this inability to take in new ideas about the world which led to the intellectual failure of dementia: 'unable to form a true and just idea of objects, these persons cannot compare them, or exercise abstraction or association of ideas'.<sup>93</sup> Esquirol, like his teacher Pinel, took a

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<sup>91</sup> George H. Savage, *Insanity and Allied Neuroses: Practical and Clinical* (London, 1884), p. 209. This metaphor is resonant of the 'shell' metaphor often used to describe Alzheimer's patients in the twentieth and twenty-first centuries. A direct comparison between the two is not straightforward: the 'shell' metaphor has been interpreted within the context of a particular late-modern concept of selfhood, reliant on memory and inner narrative. See Jesse Ballenger, *Self, Senility, and Alzheimer's Disease in Modern America: a History* (Baltimore, 2006), pp. 152-55.

<sup>92</sup> Prichard, *Treatise on Insanity*, pp. 86-87.

<sup>93</sup> *Ibid.*, pp. 86-87.

broadly 'associationist' approach to mental activity.<sup>94</sup> Often linked to the work of seventeenth-century English philosopher, John Locke, associationism was an empiricist theory of mind. Associationists held that there are no *a priori* elements of mind, that everything we know has been gleaned from the outside world via our senses. All thought, they suggested, is made up of aggregates of these sensory impressions, which are *associated* with one another in the mind.<sup>95</sup> Sensation was thus essential to thought and reason. Also essential to reason, according to Esquirol, was 'attention', the faculty of mind which acted as a 'stamp...[to] fix and preserve the constancy of [external] objects'.<sup>96</sup> The process of associating ideas required the focus of attention, so that a train of thought could be followed. In dementia, however, the 'organ of thought' was lacking in energy, depriving the sufferer of 'sufficiently strong attention' to 'exercise abstraction or association of ideas'.<sup>97</sup>

Prichard, who strongly endorsed Esquirol's description of dementia, particularly emphasised this loss of attention. He stated that 'the fundamental or essential circumstance' of dementia was 'a failure of that natural aptitude... by which... one momentary condition of the mind follows in the train of its antecedent'.<sup>98</sup> For him, then, it was not so much an inability to sense new objects, as a failure to link them successfully to others, which accounted for the 'incoherence' of dementia. This was essentially a failure of will. This difference in emphasis between Prichard and Esquirol can be explained by the influence of Scottish philosopher Dugald Stewart, whose lectures Prichard enjoyed as a medical student at Edinburgh in the early 1800s.<sup>99</sup> Stewart and his colleagues broadly agreed that the principle of association governed the organisation of ideas in the mind, but argued that 'the will' governed the process of association. For Stewart, then, an

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<sup>94</sup> Louis C Charland, 'Science and Morals in the Affective Psychopathology of Philippe Pinel', *History of Psychiatry*, 21 (2010), p. 39.

<sup>95</sup> Howard C. Warren, *A History of the Association Psychology* (New York, 1921); Robert Hoeldtke, 'The History of Associationism and British Medical Psychology', *Medical History*, 11 (1967), pp. 46-65; Rick Rylance, *Victorian Psychology and British Culture, 1850-1880* (Oxford, 2000), pp. 55-60.

<sup>96</sup> Jonathan Crary, *Suspensions of Perception: Attention, Spectacle, and Modern Culture* (Cambridge, 2001), pp. 18-19.

<sup>97</sup> Prichard, *Treatise on Insanity*, p. 87.

<sup>98</sup> *Ibid.*, p. 86.

<sup>99</sup> Hannah Franziska Augstein, *James Cowles Prichard's Anthropology: Remaking the Science of Man in Early Nineteenth-Century Britain* (Amsterdam, 1999), p. 4.

inability to form associations was accounted for, not by a failure in sensation and perception, but by a failure of the will in organising these sensations.<sup>100</sup> Prichard drew explicitly on this idea in his account of dementia.<sup>101</sup> Though Stewart's influence led Prichard to emphasise the failure of the will in forming associations between ideas, rather than the initial processes of sensation and perception as Esquirol had done, his conclusion was ultimately the same: unconnected ideas made a weak impression on the 'sensorium', and could therefore be neither recalled nor compared.

Even psychiatrists who did not subscribe to the tenets of associationism described dementia in similar terms. John Charles Bucknill, who viewed the mind as a patchwork of collaborating 'faculties', rather than a continuous stream of associations, also considered the failure of attention to be the primary mental disorder in dementia. 'In dementia,' he stated, 'no object impresses a distinct idea upon the perception, although the attention may have dwelt upon it for some length of time.'<sup>102</sup> His insistence on separating the faculties of mind, however, led him to differ from Esquirol and Prichard in his assessment of the effect of dementia on the powers of reason. 'The fact is abundantly verified by experience', he declared, 'that in persons whose powers of mind are in an advanced state of decay, the judgement often remains sound.' The faculty of reason, he suggested, could continue unimpeded in dementia, as it was entirely separate from the decaying faculty of attention. Indeed, the continued integrity of the reason, he suggested, was what separated dementia from mania and other forms of insanity. Despite his insistence on this point, however, he had to concede that it was very difficult to investigate the reasoning powers of the dement, given that they could not take in new information with which to make reasoned judgments.<sup>103</sup> Ultimately, then, Bucknill agreed with Esquirol and Prichard: dementia sufferers lost their powers of sensation and perception, which led to an inability accurately to judge the world around them.

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<sup>100</sup> Hoeldtke, 'The History of Associationism and British Medical Psychology', pp. 57-58.

<sup>101</sup> Prichard, *Treatise on Insanity*, pp. 94-95.

<sup>102</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, p. 290.

<sup>103</sup> *Ibid.*, pp. 290-91.



The failure of sensation and attention in dementia was also used to explain the failure of memory. Even Bucknill, who saw memory as an entirely separate faculty of mind, conceded that the loss of attention could prevent the formation of new memories, as 'a thing which is well observed is well remembered; while circumstances to which the attention has not been energetically directed, hold in the memory but a feeble and treacherous place'.<sup>104</sup> Crichton Browne, who also broadly ascribed to faculty psychology, described the demented memory in similar terms. In senile dementia, he argued, 'dullness of perception', 'imperfection in the processes of sensation' and 'enfeeble[ment] [of] attention' were the primary symptoms. Under these unfavourable conditions, 'all new impressions made upon the mind are feeble and are speedily obliterated'. Thus, the senile dement could not make or retain memories of new or recent events. 'Deprived of recent acquisitions,' continued Crichton Browne, 'the mind busies itself with older stores'. Hence the tendency of senile dementes to confuse the past with the present: they were simply 'mak[ing] use of long past [and well-remembered] experience' to help them make sense of a 'confused and indistinct present'.<sup>105</sup> Dementia, then, was characterised not so much by the loss of memories, as by the failure of memory.

### *Dementia and Emotion*

Up until at least the 1870s, the loss of attention, sensation and perception were viewed as the primary mental failures of dementia, leading to a loss of reasoning capacity and a failure of memory. These were not, however, the only faculties which were thought to be affected by the decay of dementia. The emotions were not excluded from this general process of mental emptying. Most psychiatrists suggested that the more elevated and developed 'moral' emotions would be lost first, as 'the nobler and more complicated emotions of manhood gave way to those of a more rudimentary character'.<sup>106</sup> Bucknill suggested that the essential character of a person was revealed through this process: these 'rudimentary' emotions may

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<sup>104</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, p. 290.

<sup>105</sup> James Crichton Browne, 'Clinical Lectures On Mental And Cerebral Diseases: - V. Senile Dementia', *The British Medical Journal*, 1 (1874), p. 601.

<sup>106</sup> Buknill and Tuke, *Manual of Psychological Medicine*, p. 290.

manifest in a virtuous and happy way, if the underlying 'disposition' of the person were good.<sup>107</sup> With characteristic pessimism, Henry Maudsley took a more negative approach to the emotional tenor of dementia. The 'moral feelings', he argued, kept our essentially amoral selves under control. Their loss would result in 'peevishness and quarrelsomeness... obstinate self-opinion [and] dictatorial self-will', amongst other similarly heinous traits.<sup>108</sup> Crichton Browne suggested that the emotional attrition of senile dementia would mirror the failure of perception and sensation: in senile dementia, the feelings were no longer formed in relation to others, and 'selfish, superficial, inconsequential emotions [were] alone manifested'.<sup>109</sup> Left unable to fully take in the world around them, the dement's points of reference became increasingly internal, both cognitively and emotionally.

Eventually, even these lowly, selfish emotions would lose their force. 'In the sphere of the emotions', wrote Crichton Browne, 'throughout the whole course of senile dementia, all tends towards bluntness and impotency'.<sup>110</sup> This assessment echoed a classical characterisation of old age, as a time of calm reflection, free of emotional turmoil and excess.<sup>111</sup> Maudsley invoked this tradition explicitly: 'by the ravages of decay [the senile dement] is brought to the philosopher's ideal of freedom from passion'. Maudsley, whose attitude towards old age in general was exceptionally negative, was not being sincere in his reference to the 'philosopher's ideal'. For Maudsley, the loss of emotion was but one part of the 'common "ruin of oblivion"' which rendered the dementia sufferer completely mentally impotent, an empty psychological wasteland.<sup>112</sup>

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<sup>107</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, p. 290.

<sup>108</sup> Henry Maudsley, *The Pathology of Mind* (3rd edn, London, 1879), p. 475.

<sup>109</sup> Crichton Browne, 'Clinical Lectures On Mental And Cerebral Diseases: - V. Senile Dementia', p. 602.

<sup>110</sup> *Ibid.*, p. 602.

<sup>111</sup> In Benjamin Jowlett's translation of Plato's *Republic*, first published in the 1850s, old age is described as having 'a great sense of calm and freedom, when the passions relax their hold'.

<sup>112</sup> Maudsley, *Responsibility in Mental Disease*, p. 258. The phrase 'Ruin of oblivion' was taken from Shakespeare's *Troilus and Cressida*.

### *Dissolution and the Cognitive Paradigm*

The encroachment of the theory of dissolution into the concept of dementia in the 1880s and 1890s had two consequences for the symptomatic paradigm of dementia. Firstly, as has already been discussed, it reinforced the relationship between dementia and negative symptoms. Mercier, in particular, identified dementia with the negative element of dissolution: the loss of function. However, he also recognised that dementia patients could display positive symptoms. The dissolutionary loss of elevated nervous functions left the lower, uncontrolled, emotionally driven nervous layers to exert control. Thus, 'the display of emotion, that would normally be held in check by the controlling influence of the highest nerve regions, fails to be inhibited, and occurs from the excitation of trifling causes'.<sup>113</sup> The consequences of this loss of control might include a quick temper, general irritability, and a tendency to weep at the merest provocation. Far from becoming 'freed from passion', Mercier's senile dement was in fact more in thrall to their emotions than ever. However, if this irritability was exaggerated, and manifested in 'uproar... foul language...abuse... [and] actual violence', then Mercier considered there to be 'something more than dementia' at work.<sup>114</sup> Such positive symptoms were not manifestations of dementia, but of a positive form of insanity.

The dissolutionary model of dementia also led to an increased emphasis on the loss of the intellectual faculties. The principle of dissolution channelled the global decay of dementia through this hierarchical progression, giving priority to the loss of intellectual functions. It drew on an evolutionary psycho-physiological hierarchy, with 'judgement and reason' at the highest point.<sup>115</sup> In his 1889 *Textbook of Mental Diseases*, William Bevan Lewis stated that 'the failing mental powers [in senile dementia] illustrate the law of dissolution, whereby the highest and last-evolved members of a series fail earliest'. For Bevan Lewis, this meant that the 'power of abstract thought', and the ability to perform complex reasoning, would

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<sup>113</sup> Mercier, *Sanity and Insanity*, p. 378.

<sup>114</sup> *Ibid.*, pp. 378-79.

<sup>115</sup> Crichton Browne, 'On Old Age', p. 732.

fail first. Next came 'the association of ideas', 'the contrasting faculties', 'the creative operations' and 'the higher emotional states'. Bevan Lewis placed all of these broadly intellectual capacities *before* the loss of memory in the progressive decay of dementia, although that too would come 'sooner or later'.<sup>116</sup> The hierarchical disintegration of dissolution thus placed the intellectual functions at the vanguard of the dementing process.

### *The Localisation of Dementia*

At the end of the nineteenth century, this intellectual paradigm was co-opted and reinforced by localisationist neurologists. 'It is universally known,' wrote Bernard Hollander, in a 1901 survey of 'The Present State of Mental Science', 'that in senile dementia, and dementia of any kind... the greatest atrophy occurs in the frontal lobes.'<sup>117</sup> In phrenology, the localised psycho-pathological theory which was influential in the early part of the nineteenth century, the frontal part of the brain was assigned to the faculties of intellect and reason.<sup>118</sup> When neurologists returned to the idea of cerebral localisation in the latter part of the nineteenth century, the frontal lobe – physically situated at the very top of the nervous hierarchy – was again broadly defined as the seat of the highest intellectual functions.<sup>119</sup> David Ferrier, one of the key figures in the revival of cerebral localisation in the 1870s, suggested that

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<sup>116</sup> Bevan Lewis, *A Text-Book of Mental Diseases*, pp. 414-15.

<sup>117</sup> Bernard Hollander, 'The Present State of Mental Science: The First of a Series of Papers on the Localisation of Mental Functions in the Brain', *Journal of Mental Science*, 47 (1901), p. 313.

<sup>118</sup> Roger Cooter, *The Cultural Meaning of Popular Science: Phrenology and the Organization of Consent in Nineteenth-Century Britain* (Cambridge 1984). For an examination of the relationship between phrenology and later theories of localization, see Young, *Mind, Brain and Adaptation*, *passim*.

<sup>119</sup> Arthur Benton, *Exploring the History of Neuropsychiatry* (Oxford, 2000), pp. 70-82.

The phrenologists have... good grounds for localising the reflective faculties in the frontal regions of the brain, and there is nothing inherently improbable in the view that frontal development in special regions may be indicative of the power of concentration of thought and intellectual capacity in special directions.<sup>120</sup>

Ferrier cautiously suggested that the frontal lobes were important factors in the development of advanced intellectual capacity. In justifying his view of the frontal lobes as the seat of the intellect, Ferrier essentially created a 'localised' view of dementia. In 1873, Ferrier had undertaken a series of experiments on macaque monkeys at the West Riding Asylum at Wakefield, under the invitation of James Crichton Browne. On 2<sup>nd</sup> December, he removed the frontal lobes from one of these monkeys, chosen especially for his 'lively and intelligent' nature. The monkey lived for five days after the operation, during which time he was closely observed. Ferrier noted that, after the operation, he continued to respond to stimuli, but ate and drank in a 'mechanical' fashion, ignored his surroundings and kept falling asleep. 'The condition resembled that of dementia,' he wrote. He claimed that the monkey's faculties of sensation and motion remained intact, but noted that he failed to learn that he should not touch a burning match, and showed no interest in another monkey placed in his cage.<sup>121</sup> Thus, this experiment, as well as apparently demonstrating the importance of the frontal lobes to the intellect, mobilised and reinforced a concept of dementia which consisted exclusively of cognitive impairment. The faculties of sensation, previously a key part of the concept of dementia, played no part in this localised dementia. Thus, the attribution of dementia to the wasting of the frontal lobes significantly reinforced a cognitive paradigm.

In the latter decades of the nineteenth century, a handful of psychiatrists, particularly those who were associated with Wakefield (where Ferrier undertook

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<sup>120</sup> David Ferrier, *The Functions of the Brain* (London, 1876), p. 288.

<sup>121</sup> David Ferrier, 'Experiments on the Brain of Monkeys – No. 1', *Proceedings of the Royal Society*, 23 (1875), pp. 98-101.

his early research), drew on the principle of cerebral localisation in their discussions of dementia, mental weakness, and ageing.<sup>122</sup> In the years following Ferrier's experiments, however, many grew sceptical of the claims of cerebral localisation, as it did not provide them with the straightforward correlation between mental and encephalic pathology that they so desired.<sup>123</sup> It was not until Joseph Shaw Bolton's work in the early 1900s, that the principle of dissolution, the prefrontal localisation of the intellect, and the association of dementia with prefrontal wasting, were neatly drawn together into a comprehensive psycho-physiological picture. Bolton – like Hughlings Jackson and the psychiatrists and psycho-physiologists who built on his work – relied on an associationism to explain mental processes. Bolton divided the brain into three areas, roughly situated in ascending order from the top of the spine to the front of the brain. The lowest region was responsible for collecting impressions from the senses, the next region organised these impressions into simple perceptions, and the highest region arranged them into complex thoughts. This highest frontal region, Bolton claimed, was both 'the last part of the cerebrum to be evolved' (in the development of the individual person and of the human species as a whole) and 'the first part of the cerebrum to undergo dissolution in dementia'.<sup>124</sup> The primacy of the decay of the faculties of sensation which had characterised earlier descriptions of dementia, was therefore thoroughly overturned. In Bolton's articles, dementia was presented literally as 'dying from the top' – from the top of the brain, from the top of the nervous hierarchy, and from the top of the hierarchy of mental functions.<sup>125</sup>

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<sup>122</sup> William Bevan Lewis, 'Cerebral Localisation In Its Relationships To Psychological Medicine', *The British Medical Journal*, 2 (1883), p. 626; Crichton Browne, 'On Old Age'; George H. Savage, 'An Address Delivered At The Opening Of The Section Of Psychology, At The Annual Meeting Of The British Medical Association In Belfast, July And August, 1884', *The British Medical Journal*, 2 (1884), p. 242; James Shaw, 'Cases Bearing On Cerebral Localisation', *Journal of Mental Science*, 1 (1882), p. 772.

<sup>123</sup> Michael J. Clark, 'The Data of Alienism': Evolutionary Neurology, Physiological Psychology, and the Reconstruction of British Psychiatric Theory, c.1850 -c.1900', (PhD Thesis, University of Oxford, 1982), p.178-96.

<sup>124</sup> Bolton, 'Amentia and Dementia', pp. 226-7. See also Joseph Shaw Bolton, 'The Functions of the Frontal Lobes', *Brain*, 26 (1903), pp. 215-41; Joseph Shaw Bolton, 'A Contribution to the Localization of Cerebral Function, Based on the Clinico-pathological Study of Mental Disease', *Brain*, 33 (1910), pp. 26-148.

<sup>125</sup> This was a common paraphrase of a statement reportedly made by Jonathan Swift, referenced by nineteenth-century psychiatrists, to describe his own fears of mental deterioration: 'I shall be like

The cognitive paradigm of dementia also served to bolster the theory of cerebral localisation. As one neurologist put it in 1904, 'Histological investigation... does not help us in determining whether or not the frontal lobe is the seat of higher psychic functions or their nature'.<sup>126</sup> A brain on a slab could not reveal the secrets of mental functioning: for this, other types of evidence were needed, from either comparative anatomy, experimentation on living animals as practised by Ferrier, or from the comparison of a person's mental attributes during life and their brain after death. As sociologist Susan Leigh Star put it, in order to justify their claims, localisationist neurologists had to 'triangulate' evidence from the epistemologically disparate realms of clinical medicine, experimental physiology, neurosurgery and post-mortem investigation. In doing so they 'usually took evidence in an uncritical fashion'.<sup>127</sup> Uncertainties in the clinical identity of different mental disorders were flattened by neurologists seeking to justify their theories. Thus, a limited concept of dementia, as a loss of intellectual function, was used to justify claims about the localisation of these functions. At the end of a paper published in *Brain* in 1903, in which Bolton presented the morbid anatomy of several brains which showed pre-frontal wasting, he declared that

The writer... considers it proved that the great anterior centre of association lying in the prefrontal region is underdeveloped on the one hand, in all grades of primary mental deficiency, and on the other undergoes primary atrophy pari passu with the development of dementia; it is therefore the region of the cerebrum which is concerned with the performance of the highest coordinating and associational processes of mind.<sup>128</sup>

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that tree [whose upper branches were decaying] – I shall die at the top'. See 'Habits and opinions of the poets', *The Metropolitan Magazine*, 25 (1839), p. 19; Savage, *Insanity and Allied Neuroses: Practical and Clinical*, p. 76; Crichton Browne, 'Clinical Lectures On Mental And Cerebral Diseases: - V. Senile Dementia', p. 607.

<sup>126</sup> Alfred W. Campbell, 'Histological Studies on the Localisation of Cerebral Function', *Journal of Mental Science*, 50 (1904), p. 655.

<sup>127</sup> Susan Leigh Star, *Regions of the Mind: Brain Research and the Quest for Scientific Certainty* (Stanford, 1989), pp. 96-117.

<sup>128</sup> Bolton, 'The Functions of the Frontal Lobes', p. 238.

For Bolton, as for Hollander, the wasting of the frontal lobe which was observed in dementia patients ‘proved’ that the frontal lobe was the seat of the intellect, which itself proved, in a somewhat circular fashion, that dementia was a failure of intellect. Thus, together, associationist psychology, localisationist physiology, and the dissolutionary theory of insanity, produced an unequivocally cognitive paradigm of dementia.

## Models of Ageing

### *The Bodily Economy; the Exhaustion of Life*

This section will turn from dementia to senility, and examine the ways in which different models and explanations of ageing were mobilised in psychiatric texts. One of the most significant was the ‘bodily economy’ model.<sup>129</sup> The idea of that the body operates through a fixed vital economy, spending the energy endowed to it at birth, has provided one of the most enduring explanations of the ageing process. The slowing of physical movements, the visible shrinking and contraction of the body, and the seemingly inevitable fact of death, can all be explained by a depletion, and eventual exhaustion, of an innate vital force. The idea of a fixed bodily economy was closely related to the vitalist theory of organic life – popular in the eighteenth century – which posited that organic life functions through the operation of a specific ‘vital’ or ‘animal’ power.<sup>130</sup> This model should not, however, be conflated with vitalism specifically; as Daniel Schäffer has pointed out, the concept of ‘successive loss of inner, inborn vital principle... through a process of self- or external consumption’ has been a feature of discussions of ageing for centuries, and cuts across quite different theories of bodily function, from the humoral to the iatro-mechanic.<sup>131</sup> When pathological-anatomical investigations

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<sup>129</sup> This model has been referred to in various ways: Carole Haber has called it the ‘vitality model’; Hilary Marland, the ‘fixed fund of energy’; Jesse Ballenger, ‘endogenous vitalism’; Hans-Joachim von Kondratowicz ‘account theory’; Anne-Julia Zwierlein, simply ‘vitalism’. I have chosen the term ‘bodily economy’, used by Athena Vrettos amongst others, as it avoids confusion with the more specific biological theory of ‘vitalism’, and also encompasses models which include some replenishment of the body’s energies through nutrition.

<sup>130</sup> See for example Catherine Packham, *Eighteenth-Century Vitalism: Bodies, Culture, Politics* (Houndmills, 2012).

<sup>131</sup> Daniel Schaefer, *Old Age and Disease in Early Modern Medicine* (London, 2010), p. 173.



brought new insights into the structure of the ageing body in the early nineteenth century, the model of the vital economy still did not disappear. According to Carole Haber, most physicians in England and America found 'little conflict' between the new pathological vision of the aged body and the older, vitally-exhausted one. The lesions and the bodily economy were 'neatly combined': 'the tissue or cell degenerated which the organism systemically wasted away'.<sup>132</sup>

The fixed bodily economy idea endured because it was adaptable. New scientific and social ideas drew on the same economic principles. The second law of thermodynamics, developed in the 1840s, posited that energy within a closed system was not perfectly conserved, but would always eventually dissipate.<sup>133</sup> Under this new physical law, running out of energy came to be seen as the fate of the universe, not just of the individual. Historian, Anson Rabinbach, has described the way in which the second law of thermodynamics, and the idea of the bodily economy, were used in discussions of work and labour to tie bodily efficiency to mechanical efficiency.<sup>134</sup> The bodily economy made it easy for bodily activity, and the effects of ageing, to be moralised and politicised. The signs of ageing could be taken as signs of an exhausting lifetime of debauched, or simply improper, activity. Self-preservation in old age necessitated the careful conservation of resources. Historians, Thomas Cole and Anne-Julia Zwierlein, have connected this mid-Victorian interest in prudent vital spending to similar concerns for thrift in the middle-class household and in capitalist businesses.<sup>135</sup> An unhealthy and impoverished old age was thus conceptualised as a consequence of wasteful expenditure, financially and vitally.

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<sup>132</sup> Carole Haber, *Beyond Sixty-Five: the Dilemma of Old Age in America's Past* (Cambridge, 1983), p. 65.

<sup>133</sup> J. Edward Chamberlin, 'Images of Degeneration: Turnings and Transformations', in J. Edward Chamberlin and Sander L. Gilman (eds), *Degeneration : the dark side of progress* (New York, 1985), pp. 270-72; Anson Rabinbach, *The Human Motor: Energy, Fatigue, and the Origins of Modernity* (New York, 1990), pp. 3-4.

<sup>134</sup> Rabinbach, *The Human Motor*, passim.

<sup>135</sup> Thomas R. Cole, *The Journey of Life: a Cultural History of Aging in America* (Cambridge, 1992), p. 98; Anne-Julia Zwierlein, 'Exhausting the Powers of Life', in Anne-Julia Zwierlein, Katharina Boehm and Anna Farkas (eds), *Interdisciplinary Perspectives on Victorian Old Age* (Hoboken, 2013), p. 39.

As these examples suggest, the idea of the bodily economy was pervasive in Victorian culture. As a medical explanation of ageing, however, some nineteenth-century physicians expressed concern over the logic of the fixed vital economy. In the entry on 'old age' to his monumental *Dictionary of Practical Medicine*, James Copland explained that all visible and invisible signs of ageing were 'more or less remote effects of the failure of the vital endowment of the frame'. At the same time, however, he pointed out that ageing could not be caused by the progressive exhaustion of the energy endowed to us at birth, as 'parents cannot possibly impart to the embryo more [energy] than they possess'. Copland's alternative was to suggest that it was the processes of nutrition which failed in old age; that old bodies were less efficient at replenishing their spent reserve of energy.<sup>136</sup> Physicians who wrote specifically about the physical effects of ageing echoed Copland's objections to the fixed endowment of energy model. Psychiatrists, however, showed no such qualms.<sup>137</sup> Thomas Laycock, who held explicitly vitalist views, suggested that 'Old dogs and monkeys do not become irritable from experience alone, but from the decline of vital powers. It is not otherwise in man.'<sup>138</sup> As late as 1890, Charles Mercier described this expenditure of energy throughout the course of life in terms of classical mechanics:

The impetus, that was given to the organism at conception, has carried it on through the process of development to manhood, has sustained it in activity throughout a long life, but with each year that has passed a portion of the initial velocity has been dissipated. The friction with the world has tended constantly to bring the organism to rest, and as its career approaches termination, it moves more and more slowly.<sup>139</sup>

This 'slowing' in old age, according to Mercier, had physical effects in the 'diminished energy of movement', and mental effects in the 'diminished activity of

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<sup>136</sup> James Copland, *A Dictionary of Practical Medicine* (London, 1858), pp. 46-47.

<sup>137</sup> Barnard Van Oven, *On the Decline of Life in Health and Disease: Being an Attempt to Investigate the Causes of Longevity; and the Best Means of Attaining a Healthful Old Age* (London, 1853), p. 19.

<sup>138</sup> Thomas Laycock, *Mind and Brain* (2nd edn, London, 1869), p. 419.

<sup>139</sup> Mercier, *Sanity and Insanity*, pp. 303-4.

mind'. Due to this loss of energy, he suggested, the process of thought literally slowed down, the intellect becoming 'dull' and 'lethargic'. The 'inertia' of the nervous molecules prevented new memories from being formed. The model of the bodily economy thus neatly tied together physical ageing and the decline of the ageing mind.<sup>140</sup>

The idea of the fixed bodily economy was used to describe many mental conditions, at all stages of life. 'Neurasthenia' was perhaps the characteristic disorder of the depleted vital economy in the nineteenth century.<sup>141</sup> This was a protean disorder, whose symptoms included 'anxiety, despair, phobias...insomnia...inattention, extreme fatigue, palpitations, migraine, indigestion, and impotence'.<sup>142</sup> It was, then, significantly less severe than dementia: neurasthenia could incapacitate its sufferers, but would rarely lead to their complete mental disintegration, and was usually entirely curable. It was also more refined than dementia, generally considered to be a disease of the middle classes. Like dementia, the heterogeneous disease of neurasthenia was held together by its aetiology: a depletion of the vital nerve force. This could be brought about by overwork or over-excitement, or anything else which taxed the body's reserves of nervous energy. It was variously described as the characteristic condition of modern, civilised man, and as an enfeeblement brought about by the exhaustion of having a female body.<sup>143</sup> An American physician named George Miller Beard was widely regarded as the 'father of neurasthenia'. He emphasised the middle-class male type of neurasthenic, exhausted by 'the fast pace of modern life'.<sup>144</sup> Beard also wrote extensively on old age, and included this research in his most famous book, *American Nervousness*. Beard's view of old age, the period in which the nerve force was almost spent, was very pessimistic. Many of the world's problems, he

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<sup>140</sup> Mercier, *Sanity and Insanity*, pp. 306-7.

<sup>141</sup> For more on neurasthenia, see the essays in Marijke Gijswijt-Hofstra and Roy Porter (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam, 2001); Janet Oppenheim, *Shattered Nerves: Doctors, Patients, and Depression in Victorian England* (New York, 1991), pp. 79-119; Andreas Killen, *Berlin Electropolis: Shock, Nerves, and German Modernity* (Berkeley, 2006).

<sup>142</sup> Marijke Gijswijt-Hofstra, 'Introduction', in Gijswijt-Hofstra and Porter (eds.), *Cultures of Neurasthenia*, p. 2.

<sup>143</sup> Hilary Marland, 'Uterine Mischief': W.S. Playfair and his Neurasthenic Patients', in Gijswijt-Hofstra and Porter (eds.), *Cultures of Neurasthenia*, pp. 118-40.

<sup>144</sup> Gijswijt-Hofstra, 'Introduction', p. 2.

suggested, could be put down to the 'barbarous folly' which allowed old, exhausted men to hold most of the power.<sup>145</sup> For Beard, both the neurasthenic and the old person were left mentally and physically crippled by their loss of nervous energy.

Though neurasthenia was not itself conceptualised as premature ageing, the same explanatory model was used to explain why some people aged – physically and mentally – before others. 'The powers of all are limited', suggested Prichard in his 1835 *Treatise*, and 'a life of too much activity and... mental exertion... excessive anxiety and eagerness in pursuit of business, or intense and unremitted application to studies of any kind' was liable to bring on senile dementia at an early age.<sup>146</sup> This warning against over-exertion in work and business was difficult to reconcile with the Victorian values of hard work and unceasing productivity. Zwierlein argues that mid-Victorian writers circumvented this contradiction by suggesting that hard work itself promoted efficient use of energy, claiming that 'both excess and indolence could thus be fatal'.<sup>147</sup> James Crichton Browne was a supporter of such prudent expenditure of energy. In the 1870s and 1880s, he took a keen interest in education reform, with a particular concern for the nervous disease which might result from the pressures of over-education and over-examination, especially amongst the poor.<sup>148</sup> In his 1874 lecture on senile dementia, he also warned of the dangers of 'feverish brain-work' in the old, as a potential inducement to mental failure. At the same time, however, he was keen to emphasise that he did not advocate an idle life and idle old age: 'it is not pure brain-work, but brain-excitement or brain-distress, that eventuates in brain-degeneration and disease'. Indeed, it was not the poor whom he considered to be most in danger at this time of life, but the idle rich:

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<sup>145</sup> George Miller Beard, *Legal Responsibility in Old Age* (New York, 1874), p. 22, as quoted in Cole, *The Journey of Life*, pp. 163-68. See also Stephen Katz, *Disciplining Old Age: the Formation of Gerontological Knowledge* (Charlottesville, 1996), pp. 88-89; W. Andrew Achenbaum, *Old Age in the New Land: the American Experience since 1790* (Baltimore, 1978), pp. 45-47.

<sup>146</sup> Prichard, *Treatise on Insanity*, p. 92.

<sup>147</sup> Zwierlein, 'Exhausting the Powers of Life', pp. 41-42.

<sup>148</sup> Michael Neve and Trevor H. Turner, 'What the Doctor Thought and Did: Sir James Crichton-Browne (1840-1938)', *Medical History*, 39 (1995), pp. 412-13.

No more pitiable picture can, I think, be conceived, than the retired man of business wandering about in listless ineptitude and dreary opulence... with the great burden of fatuity settling on his mind. A lively bankruptcy must be delightful when compared with the state of that man. Struggling poverty would be a positive blessing to him.<sup>149</sup>

Crichton Browne thus managed to marry a firm commitment to middle-class Victorian values of industry and forbearance, with an underlying belief in the need to conserve our vital forces.

The image of the senile dement presented here by Crichton Browne is not just middle class, of course, but male: 'the retired man of business'. This is an interesting choice, given the prominence of the vital economy in contemporary medical discussions of *women's* bodies, including those written by Crichton Browne. Women's reproductive systems were thought to be particularly taxing on their reserves of vital energy. This reproductive exhaustion was used to explain women's limited mental capacity, and to endorse the need for passivity and calm in their lives.<sup>150</sup> When it came to old age, however, this model of women as exhausted and fragile broke down. If women's body economies are so greatly taxed during their reproductive lives, it logically followed that women will feel the effects of this massive expenditure – and thus age and die – earlier than men. Yet nineteenth-century observers could not ignore the mortality gap: in the nineteenth century, as in the present, women generally outlived men.<sup>151</sup> Indeed, the longer life-expectancy of women was explained by the particular stresses placed on *men's* bodily economies throughout their lives and their exhausting public roles. Crichton Browne, a great opponent of women's education, wrote in 1891 that 'Women, who

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<sup>149</sup> Crichton Browne, 'Clinical Lectures On Mental And Cerebral Diseases: - V. Senile Dementia', p. 603.

<sup>150</sup> Ornella Moscucci, *The Science of Woman: Gynaecology and Gender in England, 1800-1929* (Cambridge, 1990), p. 104; Hilary Marland, *Health and Girlhood in Britain, 1874-1920* (Houndsmills, 2013), pp. 17-21.

<sup>151</sup> Pat Thane, 'Social Histories of Old Age and Aging', *Journal of Social History*, 37 (2003).p. 95.

have not yet to bear the brunt of competition as much as men, reach advanced ages in far larger proportion than men do.’<sup>152</sup>

The stereotype of the powerful, intellectual men, brought low by dementia – exemplified by poet and historian Robert Southey, adopted as a case study in Bucknill and Tuke’s *Manual of Psychological Medicine* – was a trope in these writings, but was not all-encompassing.<sup>153</sup> ‘Senile dementia has been spoken of as “the last infirmity of noble minds”’, wrote Crichton Browne (quoting Bucknill and Tuke), ‘but experience will convince you that it is also the infirmity of minds which have no pretension to nobility’.<sup>154</sup> If men were often presented as the ideal type of senile dement, the actual examples presented in these texts were more often women, presumably due to the greater numerical abundance of old women in the asylum, and outside it. Certainly, old women (and men) were not immune to the effects of ubiquitous Victorian gendered stereotyping but, medically speaking, the aged had ‘passed through that excitable and stormy period of nervous life which corresponds to the activity of the sexual functions’ and, in this sense, become de-gendered by their age.<sup>155</sup> Where concerns about gendered behaviour were brought up in discussions of senile insanity, it usually reflected concerns about a change in habitual behaviour (which was necessarily gendered).<sup>156</sup> Male sexuality was thought to be more persistent into old age than female sexuality, but in a precarious state, prone to perversion: Crichton Browne warned of the ‘octogenarian celibate [who] seeks out an Abishag to comfort his chill decrepitude’.<sup>157</sup> Certain psychiatrists implied that senility would have a feminising effect. Advice for a mentally healthy old age often involved withdrawing from the cut-and-thrust of public life, into the quiet, rhythmic calm of the domestic sphere. Henry Maudsley – ‘the high priest of

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<sup>152</sup> Crichton Browne, ‘On Old Age’, p. 79.

<sup>153</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, pp. 127-29.

<sup>154</sup> Crichton Browne, ‘Clinical Lectures On Mental And Cerebral Diseases: - V. Senile Dementia’, p. 603.

<sup>155</sup> Francis E. Anstie, ‘On Certain Nervous Affections of Old Persons’, *Journal of Mental Science*, 16 (1870), pp.39-40.

<sup>156</sup> This follows the argument of David Wright, ‘Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England’ in Andrews and Digby (eds), *Sex and Seclusion*, pp.166-67.

<sup>157</sup> Crichton Browne, ‘Clinical Lectures On Mental And Cerebral Diseases: - V. Senile Dementia’, p. 602; Clouston, *Clinical Lectures on Mental Diseases*, pp. 564-65; Henry Maudsley, *The Pathology of Mind* (2nd edn, London, 1895), p. 212; W. C. McIntosh, ‘On Some of the Varieties of Morbid Impulse and Perverted Instinct’, *Journal of Mental Science*, 11 (1866), p. 525.

the fixed fund of energy' - was particularly critical of old men who attempted to maintain their masculine public role beyond their mental capacity to perform it.<sup>158</sup> Charles Mercier, on the other hand, used the idea of an evolutionary gender difference to express the effects of senile dementia:

When an old man's other faculties begin to fail, he becomes incapable of feelings of a high degree of elevation. On the occurrence of a *cause celebre* he fails to rise to the feeling of justice, but takes the feminine view that it would be cruel to punish the offender.<sup>159</sup>

According to Mercier, then, the retrogression of old age brought old men onto an evolutionary par with women.

Throughout this period, as has already been discussed, dementia was broadly conceptualised as a loss of energy leading to a loss of mental capacity. Anything which exhausted the body's reserves of vital or nervous energy – acute emotional shock, physical illness, or another long-term mental disorder – could bring on dementia. 'Seeing that the pathological condition of dementia is an emptiness of the storehouse of energy,' wrote Charles Mercier, 'it is evident that anything which produces an excessive emptying of these stores may produce dementia'.<sup>160</sup> Thomas Clouston gave one of the most comprehensive lists of those things which might empty this storehouse:

[Dementia] frequently occurs in and after bodily diseases, especially after fevers. It also always occurs in the process of starvation to death. It frequently is seen after the exhaustion of long journeys, great exertions, severe campaigns, and great mental tension, strains, or efforts, such as business crises,

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<sup>158</sup> Henry Maudsley, *The Physiology of Mind* (London, 1879), p. 537.

<sup>159</sup> Mercier, *Sanity and Insanity*, p. 309.

<sup>160</sup> *Ibid.*, p. 374.

sieges, etc. It also occurs after sudden or great emotional shocks, such as loss of children.<sup>161</sup>

He then described secondary dementia – ‘dementia *par excellence*’ – as the form of dementia brought on by the exhaustion caused by other forms of insanity. Clouston’s list of the causes of dementia thus included physical, mental, emotional and intellectual factors. These causes could be acute or long-term. Clouston’s list also included the longest-term cause of all, ‘the process of starvation to death’. This aetiological model, of physical and mental exhaustion as the cause of dementia, allowed ageing to sit comfortably alongside these myriad other causes. In 1867, Henry Maudsley classified the dementia of old age as a form of ‘secondary dementia’, because of the ‘unanswerable argument that it is secondary to the feverish disease of life’.<sup>162</sup> German Berrios has described this classification as ‘strange’ and Maudsley’s justification of it as a ‘bizarre way out’.<sup>163</sup> However, far from being strange or bizarre, this justification was entirely consistent with the mid-nineteenth-century understanding of aging and of dementia. Dementia was thought to be generally caused by an exhaustion of the nervous system, and the progress of years was one of the things which could bring this on. Some people would find themselves weakened when they were young, by illness, accident, or imprudent living, but eventually everyone would find themselves weakened by the exhaustion of a long life.

Carole Haber has described the concept of the bodily economy as a ‘metaphoric model of ageing’.<sup>164</sup> It was certainly a concept which leant itself to metaphoric description. In the *Manual of Psychological Medicine*, Tuke used the metaphor of a flame to explain the consumption of energy in dementia, when ‘the oil which should have sustained the lustre of an entire life’, was reduced to ‘ashes in the socket’.<sup>165</sup> Charles Mercier also likened ageing to a dying flame.<sup>166</sup> Henry

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<sup>161</sup> Clouston, *Clinical Lectures on Mental Diseases*, pp. 266-67.

<sup>162</sup> Henry Maudsley, *The Pathology of Mind* (London, 1895), p. 347.

<sup>163</sup> G. E. Berrios, *The History of Mental Symptoms*, p. 182.

<sup>164</sup> Haber, *Beyond Sixty-Five*, p. 65.

<sup>165</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, p. 121.

<sup>166</sup> Mercier, *Sanity and Insanity*, p. 306.



Maudsley used the more up-to-date analogy of a steam engine.<sup>167</sup> At the same time, however, most psychiatrists made it clear that they considered this vital or nervous energy to be much more than a metaphor. They viewed the loss of vital energy as a material phenomenon. 'By the old writers,' wrote Maudsley,

it was said that the "vital spirits" were secreted from the blood in the brain and were diminished or exhausted by frequent or prolonged use. With the necessary change of terms, that is probably very much what happens. The elements of nerve substance are secreted from the blood in the nerve-cells, and, undergoing decomposition during function, are diminished or exhausted by frequent or prolonged use.<sup>168</sup>

Here, Maudsley suggested that the key components in maintaining vitality are 'elements of nerve substance', carried by the blood to nourish the activity of the nerve cells. Other physicians suggested different substances as the material basis for 'vital spirits'. Charles Brown-Séquard (1817-1894) was a French neurologist with an international career and reputation.<sup>169</sup> In the early 1860s, during a period working at the National Hospital for the Paralytic and Epileptic in London, he was a key influence on John Hughlings Jackson.<sup>170</sup> In the 1880s, as his own old age approached, Brown-Séquard turned his considerable talents to the amelioration of the ageing process. In 1889, he caused a sensation by claiming to have rejuvenated his 72-year-old body with 'an extract of animal sex-glands'. Loss of seminal fluid had long been associated with a loss of vital energy in anti-onanistic literature. Brown-Séquard turned this discourse on its head, by suggesting that an injection of seminal fluids could re-vitalise the aged body.<sup>171</sup> He died five years later.

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<sup>167</sup> Maudsley, *The Physiology of Mind*, p. 80.

<sup>168</sup> Maudsley, *The Physiology of Mind*, p. 81.

<sup>169</sup> Finn, 'The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century', p. 141.

<sup>170</sup> Dewhurst, *Hughlings Jackson on Psychiatry*, p. 12.

<sup>171</sup> Cole, *The Journey of Life*, p. 179; W. Andrew Achenbaum, *Crossing Frontiers: Gerontology Emerges as a Science* (New York, 1995), p. 40.

Blood often stood in as the material provider of this vital force. For Thomas Laycock, an 'abundance of [vital] force' was indicated by 'good blood circulating through a healthy lung, and within a healthy, well-formed brain'.<sup>172</sup> Thus, a lack of blood-flow, or a degradation of the blood's quality, was often included in explanations or descriptions of the ageing process and its mental consequences. In his 1870 article, 'On certain nervous affections of old persons', neurologist Francis E. Anstie (1833-74) argued that the nervous system, being the most elaborate part of the human body, relied on 'the constant maintenance of a more perfect and elaborate apparatus of blood supply' than any other part of the organism. For this reason, he suggested, it was the nervous system which often 'exhibit[ed] the first effects of diminished vital power' in old age.<sup>173</sup> 'If we could comprehend... the blood supply to the brain', wrote George Fielding Blandford (1829-1911) in 1871, 'we should go far towards explaining most of the phenomena of brain function and disorder'.<sup>174</sup> Restricted blood flow was thus seen as a characteristic of insane bodies, as well as aged ones. The identification of blood with the bodily economy linked the loss of vital energy to the most commonly cited physiological alteration of ageing: hardening and thickening of the arteries.

### *Old Bodies: Arteries and Atrophy*

The centuries-old saying 'a man is as old as his arteries' had, according to Carole Haber, 'achieved the status of a maxim' by the nineteenth century.<sup>175</sup> Atheroma – a thickening and increasing rigidity of the arterial walls, restricting the blood flow – featured regularly in explanations of mental disorder in old age in the second half of the nineteenth century. In his Morisonian lectures, David Skae stated unequivocally that, 'It is to this atheromatous state of the arteries... that we owe that series of symptoms comprehended under the name of *Senile Insanity*'.<sup>176</sup> Atheroma provided a physiological sign which could be easily identified by the naked eye (post-mortem, at least), and which clearly differentiated the aged body

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<sup>172</sup> Thomas Laycock, *Mind and Brain* (2nd edn, London, 1869), p. 324.

<sup>173</sup> Anstie, 'On Certain Nervous Affections of Old Persons', pp. 36-37.

<sup>174</sup> Blandford, *Insanity and its treatment*, p. 15.

<sup>175</sup> Haber, *Beyond Sixty-Five*, pp. 59-60.

<sup>176</sup> Skae, 'The Morisonian Lectures on Insanity for 1873 - Lecture III', pp. 12-13.

from the younger adult body. Atheroma could also be shown to restrict the blood flow to the brain, offering a clear structural explanation for the mental deficiencies of old age: deprived of blood and its nourishment, the brain first began to function less efficiently, and then structurally disintegrated.

This disintegration was thought to take two main forms. The first was commonly known as 'softening of the brain'. This 'softening' was another pathological phenomenon which was easy to identify in post-mortem, though it could, as Jennifer Wallis has pointed out, inhibit the identification of other pathological lesions in the brain.<sup>177</sup> The 'softened brain' was soggy and effluent, swollen with excess fluid, falling apart when attempts were made to cut into it. When caused by a failure of blood supply to the brain, as in the case of atheromatous ageing, brain softening was thought to spread from the site of this deprivation.<sup>178</sup> Some physicians and pathologists complained that the term 'softening of the brain' was applied too liberally, as a non-specific name for mental enfeeblement of all kinds, and as a lazily identified cause of death.<sup>179</sup> In spite of this, asylum pathologists continued to make use of 'softening of the brain' - even in the self-consciously scientific pages of the neurological journal, *Brain* - and it cannot be entirely dismissed as a meaningless phrase.<sup>180</sup> William Bevan Lewis - an accomplished and dedicated histologist - described softening of the brain as

a general moist condition of the white matter, which is soft, almost pasty, clings to the blade, and is apt to tear away in shreds of a dirty white hue...[T]he cerebral tissue becomes

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<sup>177</sup> Jennifer Wallis, 'Madness Incarnate: The Making of the Patient's Body in Late Nineteenth-Century Asylum Practice', (PhD Thesis, Queen Mary University of London, 2013), p. 131.

<sup>178</sup> Clouston, *Clinical Lectures on Mental Diseases*, pp. 582-83.

<sup>179</sup> Mackenzie Bacon, 'On the Mis-use of the Term "Softening of the Brain"', *Journal of Mental Science*, 18 (1872), pp. 217-18; 'English and Scotch Asylum Reports for 1878', *Journal of Mental Science*, 25 (1879), p. 214; 'The Fifty-third Report of the Commissioners in Lunacy', *Journal of Mental Science*, 46 (1900), p. 139.

<sup>180</sup> Dolly MacKinnon, 'Bodies of Evidence: Dissecting Madness in Nineteenth-century Australia', in Sarah Ferber and Sally Wilde (eds), *The Body Divided: Human Beings and Human 'Materials' in Modern Medical History* (Farnham, 2011), p. 80.

much infiltrated with serum [and there is] effusion [of fluid]  
into the ventricles and beneath the membranes of the brain.<sup>181</sup>

This process of softening and moistening in old age resonated with the humoral model of the phlegmatic aged body, and continued to be taken as a general principle.<sup>182</sup> Crichton Browne suggested that the overall softening of the brain in senile dementia corresponded with a similar softening and moistening at a cellular level.<sup>183</sup> The pathology of cerebral softening served to link ageing to chronic insanity: on the one hand, cerebral softening was said to be epitomised by ‘the water-logged brain of the chronic lunatic’; on the other, softening was considered the most common pathological feature in cases of ‘senile wasting of the brain’.<sup>184</sup> Softening was a physical embodiment of the loss of energy described above: the brain, worn out by over-exertion, or by a lifetime of use, lost its firm, buoyant structure and disintegrated into a limp ‘boggy mess’.<sup>185</sup>

The second form of encephalic disintegration described in these texts was simply called ‘atrophy’. This was a wasting away of parts of the brain, a physical loss of brain material, or, as Crichton Browne put it ‘[the] simple and numerical atrophy – the necrobiosis – of the brain’.<sup>186</sup> Psychiatrists and neurologists assumed throughout this period that brain size was an indication of mental capacity or function, and the practice of weighing the brain was a common feature of asylum post-mortem investigations.<sup>187</sup> Comparative reports on the weights of large collections of brains, published in the *Journal of Mental Science* and *Brain*, indicated

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<sup>181</sup> William Bevan Lewis, ‘Methods of Preparing, Demonstrating and Examining Cerebral Structure in Health and Disease’, *Brain*, 4 (1881), p. 82.

<sup>182</sup> H. C. Covey, ‘A Return to Infancy: Old Age and the Second Childhood in History’, *International Journal Aging Human Development*, 36 (1992), p. 82.

<sup>183</sup> James Crichton Browne, ‘Clinical Lectures On Mental And Cerebral Diseases (Concluded)’, *The British Medical Journal*, 1 (1874), p. 640.

<sup>184</sup> Bevan Lewis, ‘Methods of Preparing, Demonstrating and Examining Cerebral Structure in Health and Disease’, p. 82.

<sup>185</sup> Wallis, ‘Madness Incarnate: The Making of the Patient’s Body in Late Nineteenth-Century Asylum Practice’, p. 131.

<sup>186</sup> Crichton Browne, ‘Clinical Lectures On Mental And Cerebral Diseases: - V. Senile Dementia’, p. 601.

<sup>187</sup> From the 1890s, weighing brains was a habitual feature of post-mortems at Hanwell, although there appeared to be no attempt to systematically collect and compare this data. See Hanwell Male Autopsy Record 1891-96, H11/HLL/B/30/004; Hanwell Female Post-Mortem Book, 1901-4, H11/HLL/B/29/001.

that lunatics, the aged, women, and other inferior or degenerated persons, all had smaller and lighter brains than healthy, white, adult men.<sup>188</sup> The loss of brain material observed post-mortem provided an easy explanation for the loss of mental function in old age and dementia. In an article published in the 1850s, John Charles Bucknill suggested that the cerebral atrophy of senile dementia took place 'in extent varying with the loss of mental power which ha[d] occurred'.<sup>189</sup> Following a large-scale study of the weight of insane brains, Crichton Browne argued that states of mental weakness – idiocy and dementia – were manifested in the lightest brains. Literally devoid of thought, the skulls of the demented and imbecile were as empty as their minds. Later in the century, a more localised and compartmentalised view of the brain prompted post-phrenological comparative weight studies of the different areas of the brain, complicating this simple relationship between brain size and brain function.<sup>190</sup> As discussed above, attention shifted to the atrophy of the frontal lobes of the brain, as the pathological cause of the loss of reasoning capacity in the dementia of old age.

In an 1898 address to the MPA on 'The neuroses and psychoses of decadence', Thomas Clouston called for further investigation into 'the life-history of the neuron... in [its] stages of growth, development, and decadence'.<sup>191</sup> At the time he was writing, new histological techniques were being developed, offering new ways of describing the aged brain. However, as historians Edwin Clarke and Stephen Jacyna have argued, there was no simple relationship between these technological innovations and the development of new understandings of the structure of the brain. They argue that the theoretical frameworks within which neurologists worked dictated their interpretation of what they saw: 'conceptual

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<sup>188</sup> James Crichton Browne, 'On the Weight of the Brain and its Component Parts in the Insane', *Brain*, 2 (1879), pp. 42-67; John Thurnam, 'On the Weight of the Brain, and on the Circumstances affecting it', *Journal of Mental Science*, 12 (1866), pp. 1-43.

<sup>189</sup> As quoted in Daniel Hack Tuke, 'On the Various forms of mental disorder. 'Dementia'', *Journal of Mental Science*, 3 (1857), p. 90.

<sup>190</sup> Crichton Browne, 'On the Weight of the Brain and its Component Parts in the Insane', A. Mercier, 'On the Weight of the Brain in the Insane, with Reference to the Hemispheres, Lobes, Brain-Stem, and Cerebellum: Illustrated by Charts', *Journal of Mental Science*, 37 (1891), pp. 207-11.

<sup>191</sup> T. S. Clouston, 'An Address Delivered At The Opening Of The Section Of Psychology. The Neuroses And Psychoses Of Decadence', *The British Medical Journal*, 2 (1898), p. 304.

influence structured... histological observations'.<sup>192</sup> There are many examples of new pathological discoveries in aged brains being taken as proof of existent theoretical models. In the 1890s, pioneering Scottish neuropathologist, W. Ford Robertson (1867-1923), identified chromatolysis – the process by which the constitutive elements of the neuron broke apart and dispersed to the outer parts of the cell – as a common feature of the senile brain. He interpreted this change as a stage of cellular disintegration, and of overall brain atrophy.<sup>193</sup> Thus, in his 1900 *Text-book of Pathology in Relation to Mental Diseases*, he wrote that physiological senility consisted of, not only 'a complete disappearance of a large percentage of the cells', but also a disintegration at a sub-cellular level: 'progressive atrophy of the protoplasmic processes, shrinkage of the cell-body and loss of its angular form, dissolution of the Nissl-bodies...and disintegration of the nucleus'.<sup>194</sup> Other pathological appearances were identified in aged brains at the end of the nineteenth century. William Bevan Lewis and another asylum pathologist, A. W. Campbell, both wrote about 'spider cells', commonly present in the brains of the senile insane. These were fibrillous intrusions, made visible by new staining techniques, 'throwing off numerous delicate fibrillar processes which entwine upon the vascular walls and meander among the nerve-elements of the cortex'. Bevan Lewis interpreted these as harbingers and producers of 'senile atrophy', feeding off degenerating tissue, and furthering that degeneration by strangling the blood vessels and 'seriously interfering with the permeability of nutrient supply'.<sup>195</sup> Finer-grained histological insight, then, did little to change the overall pathological paradigm of brain-ageing as brain-atrophy. In lieu of any chance to observe the degeneration of the brain as it happened, psychiatrists and neurologists fell back on the established clinical picture of senile dementia to explain and describe the pathological process of cerebral degeneration. In his article on 'The Neuroses of

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<sup>192</sup> Clarke and Jacyna, *Nineteenth-Century Origins of Neuroscientific Concepts*, p. 60.

<sup>193</sup> W. Ford Robertson, 'Normal and Pathological Histology of the Nerve-Cell', *Brain*, 22 (1899), p. 289.

<sup>194</sup> W. Ford Robertson, *A Text-Book of Pathology in Relation to Mental Diseases* (Edinburgh, 1900), pp. 226-76.

<sup>195</sup> William Bevan Lewis, *A Text-book of Mental Diseases: with Special Reference to the Pathological Aspects of Insanity* (2nd edn, London, 1899), pp. 443, 486; Alfred W. Campbell, 'The Morbid Changes in the Cerebro-Spinal Nervous System of the Aged Insane', *Journal of Mental Science*, 40 (1894), pp. 638-49.

Decadence', Thomas Clouston localised the progressive degeneration of ageing onto different parts of the neuron, just as David Ferrier and Joseph Bolton mapped dementia onto the different areas of the brain. The 'molecular structure of the protoplasm' must, Clouston claimed, be the first neurotic element to degenerate, because the failure to assimilate new impressions was the first sign of senility. The subsequent failure of the reasoning faculties, he hypothesised, demonstrated the subsequent 'destruction' of the 'dendrites and their gemmules and the neuraxons'.<sup>196</sup> At this stage, then, the new language and concepts of cellular neurology reinforced both the pathological concept of senility as a decay of the brain, and the psycho-pathological model of senile dementia as a progressive loss of function.

At the same time – from the end of the 1890s into the first decade of the twentieth century – other histological investigations of senile brains, which would eventually shift the paradigm of brain-ageing, were taking place outside of Britain. The most famous of these was published by German neuro-pathologist, Alois Alzheimer, in 1907, in which he identified 'neuritic plaques and neurofibrillary tangles' in the brain of a demented 51-year-old woman named Auguste Deter.<sup>197</sup> Alzheimer was not entirely sure what he had discovered, though he felt it was something new. These plaques and tangles became the key pathological markers of 'Alzheimer's disease', which was named, not by Alzheimer himself, but by his senior colleague Emil Kraepelin, in the 1910 edition of his *Handbook of Psychiatry*. Kraepelin interpreted Alzheimer's disease as a severe form of senile dementia, which could also occur in pre-senile cases.<sup>198</sup> The pathology of plaques and tangles represented a departure from the simple atrophic model of senile dementia of the nineteenth century: they were focal lesions, unlike the systemic phenomena of softening and atrophy, and seemed to point to a specific disease process, rather than a generalised decay. However, although the discovery of these new pathological

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<sup>196</sup> Clouston, 'An Address Delivered At The Opening Of The Section Of Psychology. The Neuroses And Psychoses Of Decadence', p. 306.

<sup>197</sup> Konrad Maurer, Stephan Volk and Hector Gerbaldo, 'Auguste D: The history of Alois Alzheimer's first case', in Jesse Ballenger, Konrad Maurer and Peter Whitehouse (eds.), *Concepts of Alzheimer Disease: Biological, Clinical and Cultural Perspectives* (Baltimore, 2000) pp. 11-21.

<sup>198</sup> Ballenger, *Self, Senility and Alzheimer's Disease*, pp. 41-43.

lesions was reported in the *Journal of Mental Science*, their immediate impact on the general psychiatric understanding of old age and senility was limited.<sup>199</sup> Historian Martha Holstein has argued that neurologists in the early twentieth century were keen to keep Alzheimer's disease separate from senile dementia. As long as Alzheimer's was considered a separate disease entity, it could be distanced from the messy uncertainties surrounding the relationship between ageing, disease and mental deterioration.<sup>200</sup> The analysis presented in this chapter suggests a somewhat different reason for the slow adoption of Alzheimer's disease, in Britain at least. At the beginning of the twentieth century, the connection between dementia and ageing had a strong, multifaceted theoretical basis. The theory of dissolution, the symptomatic paradigm of dementia as a loss of function, the model of the bodily economy, and the pathological model of brain atrophy, all served to reinforce the connection between ageing and dementia. It would take a significant paradigmatic shift (and, as historians of Alzheimer's disease have argued, a strong political and financial incentive) for this relationship to be disrupted.<sup>201</sup>

## Second Childhood and the Phylogenic Metaphor

### *The Lebenstreppe*

The metaphor of old age as a 'second childhood' drew on and reinforced the association between ageing, dissolution, and primitivism, as this section will describe. 'The common law of life', wrote Henry Maudsley in 1883, 'is slow acquisition, equilibrium for a time, then a gentle decline that soon becomes rapid

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<sup>199</sup> M. M. Rodger, 'Alzheimer's Disease (Senium Præcox). The Report of a Case and Review of Published Cases', *Journal of Mental Science*, 59 (1913), pp. 115-16; J. H. MacDonald, 'Anatomical and Clinical Study of the so-called Senile Plaques', *Journal of Mental Science*, 58 (1912), pp. 678-79; William W. Ireland, 'German Retrospect', *Journal of Mental Science*, 44 (1898), pp. 860-74. There was no discussion of plaques and tangles in *Brain* until the late-1920s.

<sup>200</sup> Holstein, 'Ageing, Culture, and the Framing of Alzheimer Disease', p. 63.

<sup>201</sup> Ballenger, *Self, Senility, and Alzheimer's Disease in Modern America*, pp. 81-112; Thomas Beach, 'The History of Alzheimer's Disease: Three Debates', *Journal of the History of Medicine and Allied Sciences*, 42 (1987), pp. 327-49; Patrick J. Fox, 'From Senility to Alzheimer's Disease: The Rise of the Alzheimer's Disease Movement', *The Milbank Quarterly*, 67 (1989), pp. 58-102; Tom Kitwood, 'Dementia: Social Section - Part II', in G. E. Berrios and Roy Porter (eds), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London, 1995), pp. 63-71.



decay and finally death'.<sup>202</sup> This 'common law' underpinned all of the models of ageing described above: whether caused by arterial degeneration or a loss of innate vitality, ageing was an inescapable part of life, as inevitable as growth from childhood. The developmental curve – a trajectory with a hopeful, upward evolution, mirrored inevitably by a sad decline – was a central image in *fin-de-siècle* science and culture, but it had many historical precedents. The image of the *Lebenstreppe* – the 'life steps', or 'life curve' – was one of the most enduring pictorial representations of Maudsley's common law of life (Figures 1 and 2). It depicted the life course as a series of orderly steps, going up from birth to maturity, and back down towards death. It originated in sixteenth-century Holland, and by the nineteenth century had become a popular and familiar iconographic trope across Europe and America, appearing on pamphlets and prints, beer mugs and board games.<sup>203</sup> The message of the *Lebenstreppe* may have changed somewhat over time (earlier examples stressed the timelessness of the Christian soul, while later versions had a more secular emphasis on health and prudence) but the essential structural features remained remarkably stable.<sup>204</sup>

This life curve did not exist only in the realm of popular culture: by the mid-nineteenth century it had entered the burgeoning medical study of ageing. In 1853, a London doctor, Bernard Van Oven, used two diagrams to represent different models of the life course, in his book *On The Decline of Life in Health and Disease* (Figure 3). Though they illustrated different versions of the development curve – one strictly symmetrical, the other showing a more rapid and destructive decline at the end of life – both were suggestive of the rise and fall of the *Lebenstreppe*. The *Lebenstreppe* were also rhetorically present in nineteenth- and early twentieth-century psychiatry. The most negative elements of the *Lebenstreppe* image – such as the apparent physical diminishment of the ageing person as they descended back down the life curve – was particularly congruent with the cultural pessimism

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<sup>202</sup> Henry Maudsley, *Body and Will: Being an Essay Concerning Will in its Metaphysical, Physiological, & Pathological Aspects* (London 1883), p. 317.

<sup>203</sup> Hans-Joachim von Kondratowitz, 'The Medicalization of Old Age: Continuity and Change in Germany from the Late-Eighteenth to the Early Twentieth Century' in Margaret Pelling and Richard Smith (eds), *Life Death and the Elderly* (London, 1994), pp. 139-44; Cole, *The Journey of Life*, p. 114.

<sup>204</sup> Cole, *The Journey of Life*, p. 114.





Figure 2. Detail from 'The Stages of Life', (London: James Catnach, c. 1830). British Museum, 1992,0125.31, AN347203

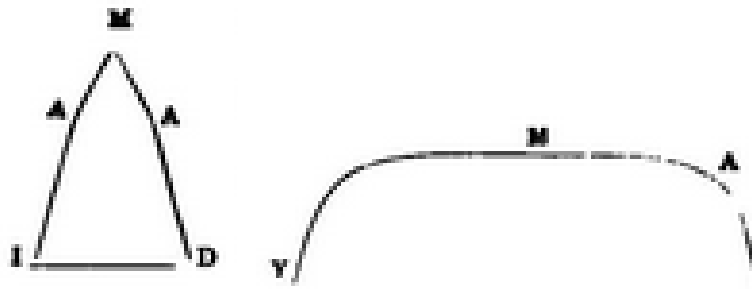


Figure 3. Detail from Bernard Van Oven, *On the Decline of Life in Health and Disease* (London, 1853), p. 36.

### Second Childhood

Thus, the symmetrical iconography of the *Lebenstreppe* justified and reinforced the ancient characterisation of old age as 'second childhood'. Growth and decline visually mirrored each other, as did the first and last stages of life: from a babe on his mother's lap, to a dying centenarian on his daughter's (Figure 1); from cradle to death bed (Figure 2). The metaphor of second childhood predates the *Lebenstreppe*, going back at least as far as Aristotle, and has endured in the face of shifting

cultural and physiological models of ageing, taking on different meanings according to the needs and milieu of the writer.<sup>206</sup> Its resilience may reflect its flexibility: social, legal, behavioural and even physical analogies have been drawn between the first and last stages of life. According to Janet Roebuck, the nineteenth century saw the early development of a chronological, legally codified definition of old age. Mostly, however, old age continued to be defined 'functionally': 'old' people were those who could not fulfil their adult role and lived, therefore, in a state of dependence.<sup>207</sup> As Theresa Mangum has pointed out, the dependent status inherent in the nineteenth-century understanding of old age was a key part of the 'second childhood' analogy.<sup>208</sup> In the *Lebenstreppe* image above (Figure 1), the infant and the centenarian both sit astride a female carer. In a discussion of lunacy and the law, published in 1868, Thomas Laycock used the 'second childhood' analogy to rail against the official status of the 'weak-minded' as legally competent. Senile dementia, he argued, placed its sufferers 'in the same position to property as infants and minors'.<sup>209</sup>

The status of senile dependents was – as we shall see in the next chapter – a political issue in the second half of the nineteenth century. Lunacy Commissioners and asylum superintendents described the senile as people who were undeniably dependent, but nevertheless unsuitable for asylum care. The senile, they argued, did not require the apparatus of care afforded to lunatics, but only such care as was suitable for children; 'a kind of senile nursery supervision'.<sup>210</sup> Such a 'senile nursery' would, it was implied, closely resemble an infant nursery, as the senile were themselves so 'childish[] in manner'.<sup>211</sup> According to Charles Mercier, senile demented showed 'an irritability of temper, a petulance and impatience, which

<sup>206</sup> Covey, 'A return to infancy', pp. 81-90.

<sup>207</sup> Janet Roebuck, 'When Does "Old Age" Begin?: The Evolution of the English Definition', *Journal of Social History*, 12 (1979), p. 417.

<sup>208</sup> Theresa Mangum, 'Little Women: The Aging Female Character in Nineteenth-Century British Literature', in Kathleen M. Woodward (ed.), *Figuring Age: Women, Bodies, Generations* (Bloomington, 1999), pp. 61-62.

<sup>209</sup> Thomas Laycock, 'Suggestions for Rendering Medico-Mental Science Available to the Better Administration of Justice and the More Effectual Prevention of Lunacy and Crime', *The British Journal of Psychiatry*, 14 (1868), p. 336-37.

<sup>210</sup> 'Medico-Psychological Association of Great Britain and Ireland', *Journal of Mental Science*, 47 (1901), p. 622.

<sup>211</sup> Henry Maudsley, *The Physiology and Pathology of Mind* (London, 1867), pp. 355-56.

reproduce the peculiarities of a spoilt child'. Any good nursery nurse could calm them down, however, as, 'like the child...they are easily coaxed into a good humour again'.<sup>212</sup> The senile, it was suggested, lost the emotional control and decorum they had developed in adulthood. 'In the cerebral decay of old age', wrote Bucknill, 'the nobler and more complicated emotions of manhood give way to those of a more rudimentary character; and the state of mind, from this change, derives its popular name of second childhood'.<sup>213</sup> Thus, the 'loss' model of ageing and dementia in nineteenth-century psychiatry reinforced the regression model present in the iconography of the *Lebenstreppe*. Through ageing and dementia, the senile lost the psychological gains of their maturity, and returned to the simpler, less developed state of their childhood.

Asylum Superintendents and the Commissioners of Lunacy sought to undermine senile demented's claim to asylum care by emphasising the 'naturalness' of their condition. 'Second childhood' was a useful metaphor in that regard: an old person with limited capacities was, it implied, no more diseased than an undeveloped child. Making such a point involved taking the metaphor of second childhood beyond social and behavioural similarities. Many nineteenth-century psychiatrists – particularly those who were influenced by evolutionary models of development and insanity – considered old age and childhood to be structurally analogous states. As Thomas Laycock put it, 'when...we speak of old age as second childhood, it is because there is the imbecility of the unformed brain in the senile organ'.<sup>214</sup> The language and concepts of dissolution, developed by Herbert Spencer and Laycock's student, Hughlings Jackson, gave late- nineteenth-century psychiatrists a theoretically unified way of describing and explaining this psycho-physiological regression. In 1890, Charles Mercier explained that:

In the term "second childhood", which is so generally applied to  
[the senile dement], we see recognised the fact that it is a

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<sup>212</sup> Mercier, *A Text-book of Insanity*, p. 110.

<sup>213</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, p. 291.

<sup>214</sup> Thomas Laycock, 'On the Naming and Classification of Mental Diseases and Defects', *Journal of Mental Science*, 9 (1863), p. 160.

degradation, a reversing of the order of evolution, a return to a more elementary and undeveloped state of things. The dotard who has lost his highest controlling regions is actually in much the same condition as the child whose highest controlling regions are not yet developed.<sup>215</sup>

In senility, according to Mercier, 'the dotard' retraced the development of their growth, eventually coming to resemble their childhood selves, physiologically and mentally. Furthermore, the state to which they would eventually be reduced, reached back even further than their own childhood. The decline of senility was more than a reversal of growth; it was 'a reversing of the order of evolution'. Both the child and the dotard embodied 'a more elementary and undeveloped state of things'.

### *Ontogeny and Phylogeny*

The analogy between the growth of the individual on the one hand, and the evolutionary development of the species on the other, was a key part of nineteenth-century evolutionary thought. The most famous formulation of this 'recapitulation theory' was published by German biologist, Ernst Haeckel, in the 1866, although the general idea had been circulating for some decades prior to this.<sup>216</sup> Haeckel summarised recapitulation as the law that 'ontogeny [individual growth] recapitulates phylogeny [the evolution of the species]'. He believed ontogeny and phylogeny to be identical, and undertook numerous embryonic investigations to show how foetuses resembled, indeed embodied, lower forms of life.<sup>217</sup> Drawing on the work of German embryologist, Ernst Von Baer, Haeckel suggested that both ontogeny and phylogeny constituted a hierarchical development from a simple form to a more complex one, from homogeneity to heterogeneity.<sup>218</sup> As previously discussed, it was through the work of Herbert Spencer that this model of

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<sup>215</sup> Mercier, *Sanity and Insanity*, p. 370.

<sup>216</sup> Stephen Jay Gould, *Ontogeny and Phylogeny* (Cambridge, 1977), pp. 113-14.

<sup>217</sup> Gould, *Ontogeny and Phylogeny*, pp. 76-85.

<sup>218</sup> Smith, 'Herbert Spencer', p. 58.

evolutionary development became prevalent in later-nineteenth-century British psychiatry and the biological sciences more generally.

From the mid-nineteenth century, then, the curve of the *Lebenstreppe* was overlaid with new meanings. A parallel curve was now imagined: one which depicted the growth of the individual as a re-enactment of the evolutionary maturation of the species. Appearing around the same time, and reaching its height in the *fin-de-siècle* period, a fear of evolutionary degeneration ‘permeate[d] nineteenth-century feeling with a model (or series of models) of decline and...images of decay.’<sup>219</sup> Individuals, societies, races, and even planets could degenerate. Degeneration was a reversal of the evolutionary process, thus degenerate peoples occupied a space lower down the evolutionary scale from healthy, white European males. Degeneration provided the phylogenic mirror to evolution, sitting alongside ageing on the right-hand side of the life-curve. Thus, children and old people (along with women, lunatics, the drunk, the immoral, the poor, the homosexual, and anyone who was not white) represented evolutionary throwbacks, sitting towards the bottom of the scale alongside humanity’s phylogenic ancestors.<sup>220</sup>

Thomas Laycock was the first British psychiatrist to draw together these parallel analogies – between ontogeny and phylogeny, childhood and old age, and ageing and degeneration – and to use them to explain and describe the decline of old age. When he outlined the retrograde characteristics of the aged body and mind in the 1860s, Laycock slipped between ontogenic and phylogenic comparisons. In old age, he claimed, the encephalic tissues returned to a state of infancy, causing the brain’s owner to return to ‘the drawing, the handwriting, and even the spelling... of his childhood’. Meanwhile, the aged body would cease to produce the chemically evolved waste product of ‘urea’, and instead begin to produce ‘uric acid’, a nutritional by-product more commonly found in birds and reptiles.<sup>221</sup> After

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<sup>219</sup> J. Edward Chamberlin and Sander L. Gilman, *Degeneration: the Dark Side of Progress* (New York, 1985), p. vii.

<sup>220</sup> Gould, *Ontogeny and Phylogeny*, pp. 121-35.

<sup>221</sup> Laycock, *Mind and Brain*, p. 413-14.

Laycock, the phylogenic metaphor of ageing reached its fullest expression in the theory of dissolution. As discussed earlier in this chapter, many psychiatrists at the end of the nineteenth century adopted John Hughlings Jackson's dissolutionary model of insanity, and used it to explain both dementia and ageing. They described senile dementia as a progressive undoing of ontogenic and phylogenic development; a regression back down the evolutionary hierarchy. 'After maturity,' wrote F. Graham Crookshank in 1906, 'the normal order of succession of sums of states of consciousness is, for each individual, the order of progression from the unstable to the stable, from the complex to the simple, from the differentiated to the undifferentiated, from the co-ordinated to the unco-ordinated - the order that is, in fact, the reverse of the order of evolution.'<sup>222</sup> Following the dissolutionary disintegration of senility, the 'elaborate nervous mechanisms' of mature, evolved adulthood gave way to 'the simpler rhythms regulating the activities of simpler forms of life'.<sup>223</sup>

### *Ontogenic and Phylogenic Memory*

If the decay of old age constituted a regression, a return to a former state, then the chronological progress of ageing actually involved moving backwards. The phylogenic metaphor thus upheld the deep-rooted association of the aged with the past. Memory had long been at the heart of this association: old people represented a gateway to knowledge of the past, as the holders of the collective historical memory.<sup>224</sup> This idea resonated with evolutionary and paleontological concerns: just as geological strata could be excavated for fossilised traces of the past, so might the psychophysiological strata of the aged mind and brain contain artefacts of human history. While this role might confer some authority on the old, it could also have the effect of turning them into fossils themselves, as living relics of the time they were called upon to remember and to represent. Memory loss, the most

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<sup>222</sup> Crookshank, 'Some Notes on the Study of Insanity', p. 54.

<sup>223</sup> Bevan Lewis, *A Text-Book of Mental Diseases*, p. 415.

<sup>224</sup> Susannah R Ottaway, *The Decline of Life: Old Age in Eighteenth-Century England* (Cambridge, 2004), pp. 108-12.



characteristic feature of senility, further affirmed the sufferer's status as a vestige of a bygone era.

The memory loss of old age was generally thought to consist of two stages: a diminished ability to form new memories, and a progressive loss of existing memories, from the most recent to the oldest. Henry Maudsley emphasised the former process, to characteristically pessimistic effect. Unable to take on new ideas and impressions, old people, he said, were stuck at an earlier stage of historical development, throwbacks to the intellectual climate of their younger years. An old man cannot make a reasoned judgment on the present, Maudsley argued, as he cannot comprehend it.<sup>225</sup> Thus, the ancient stereotype of the old man complaining about the loss of a glorious past was given an organic basis: the past would always seem to him more vivid, fuller, and more comprehensible, as his impressions of it were formed when his physiological ability to appreciate the world was at its peak. If the memory loss progressed, and forgetfulness devolved into senility, then the sufferer would lose their memories in the reverse order of acquisition, retracing the steps of their own life. In senility, the 'memory was thrown back on the far past... going back further and further, as the mind approached nearer and nearer to its second childhood'.<sup>226</sup> Stripped of their ability to form new memories and the memories of their adult life, the dement 'lives his childhood days over again'.<sup>227</sup> Dissolutionary second childhood thus represented a reliving, as well as a re-embodiment, of the first.

Memory was sometimes considered to be analogous to inheritance, as inherited characteristics were echoes of the past retrieved in the present. Thomas Laycock took this analogy the furthest, suggesting that developmental 'memory' was stored in the sperm and egg to be 'retrieved' by the developing embryo.<sup>228</sup> At a lesser extreme, the idea of an 'ancestral memory' ('organic memory theory', as Laura

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<sup>225</sup> Henry Maudsley, *Responsibility in Mental Disease* (2nd edn, London, 1876), pp. 259-60; Maudsley, *The Pathology of Mind*, p. 475.

<sup>226</sup> Bucknill and Tuke, *Manual of Psychological Medicine*, p. 191.

<sup>227</sup> Bevan Lewis, *A Text-Book of Mental Diseases*, pp. 445-46.

<sup>228</sup> T. Laycock, 'A Chapter on some Organic Laws of Personal and Ancestral Memory', *Journal of Mental Science*, 21 (1875), pp. 155-87.

Otis has called it) was widely accepted.<sup>229</sup> This theory suggested that we inherit some memories from our forebears, which appear in the form of instincts. If this is true, then our phylogenic position dictates not only the structure of our bodies and the capacities of our minds, but also what we *know*. Helen Small has noted the presence of the elderly in discussions of this theory, but has concluded that 'the old were rhetorical straw men' in the ancestral memory debate. If ancestral memories were inherited at birth, she argues, then 'age was an irrelevance' in their retrieval.<sup>230</sup> However, when we place ancestral memory into the context of recapitulation theory and the phylogenic metaphor - as Laura Otis does - age takes on greater importance. The theory of recapitulation suggested that children and old people were physiologically similar to their evolutionary ancestors, and were thus more highly governed by their instinctive, ancestral memories. According to a Spencerian evolutionary framework, those memories acquired earliest (phylogenically speaking) would be the simplest, the most organised and thus, the most robust and enduring.<sup>231</sup> The theory of ancestral memory, then, further reinforced the low place of instinct in the psychological hierarchy which, as we have seen, was already considered one of the later stages of senile dissolution. When an old person finally lost the memories of their childhood, only those memories acquired by their ancestors - those they were born with - would remain.

### **Conclusion: The Natural and the Pathological**

This chapter has argued that the understanding of both dementia and senility underwent significant changes between 1835 and the beginning of the twentieth century. At the beginning of this period, dementia was seen as a state of mental incompetence, driven by an inability to successfully sense and perceive the wider world, which could result from a wide variety of exhausting physical and emotional circumstances. By the end of it, dementia was viewed as a state of psycho-

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<sup>229</sup> Laura Otis, *Organic Memory: History and the Body in the Late Nineteenth and Early Twentieth Centuries* (Lincoln, 1994), pp. 1-52; Laura Otis, 'Organic Memory and Psychoanalysis', *History of Psychiatry*, 4 (1993), pp. 349-72.

<sup>230</sup> Helen Small, 'The Unquiet limit: Old Age and Memory in Victorian Narrative', in Matthew Campbell, Jacqueline Labbe and Sally Shuttleworth (eds), *Memory and Memorials, 1789-1914: Literary and Cultural Perspectives* (London, 2000), pp. 69-70.

<sup>231</sup> Laycock, 'A Chapter on some Organic Laws of Personal and Ancestral Memory', p. 155.

physiological dissolution, beginning with the intellect and moving down the evolutionary hierarchy, which was itself a rendition of the process of ageing. Thus, the lines between the pathological insanity of dementia, and the natural decay of old age, became significantly blurred.

This adds an interesting dimension to the historical narrative of Alzheimer's disease, described in the introduction to this thesis. Historians, campaigners and medical researchers alike hold the twentieth century as a key turning point in the medical understanding of old-age mental disorder, when 'senility' – a generalised category describing an inevitable physical and mental decline – became 'Alzheimer's disease', a disease with clear pathological markers which could theoretically affect people at any age, and was therefore theoretically treatable. This narrative is predicated on a particular – somewhat limited – interpretation on the late-nineteenth-century understanding of old-age mental disorder. Gerontologist Martha Holstein, for example, in her account of the reconceptualisation of dementia in the twentieth century, suggests that 'senility, decline and decay were synonymous to the [Victorian] medical mind' and that physicians 'us[ed] the words senile dementia and senility interchangeably to describe mental deterioration in old age and rarely distinguished between simple forgetfulness and its more malignant form'.<sup>232</sup> Holstein's claims – if applied to the end of the nineteenth century only – are not incorrect, but are incomplete. The texts written by the British psychiatrists reveal a significant level of equivocation over the question of the relationship between 'simple forgetfulness' and 'its more malignant form'. This ambivalence was underpinned by the tension between their conviction that there *was* a distinction between the two, and their adherence to a dissolutionary model of senility and dementia which rendered that distinction problematic.

In his *Clinical Lectures*, Thomas Clouston described senile insanity as a 'special intensity or irregularity in the physiological decay of the brain'.<sup>233</sup> For Clouston, then, there was a normal type of physiological senility, the type of decline

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<sup>232</sup> Martha Holstein, 'Aging, Culture and the Framing of Alzheimer Disease', in Maurer and Whitehouse (eds) *Concepts of Alzheimer Disease*, pp. 160-61.

<sup>233</sup> T. S. Clouston, *Clinical Lectures on Mental Diseases* (5th edn, London, 1898), p. 622.

that all people would eventually experience, providing they lived long enough. This normal senility, however, could be perverted or intensified, becoming then a pathological form of insanity. Senile insanity, then, was closely related to natural, old age decline – being a ‘special intensity or irregularity’ of this process – but it was not the same thing: normal old-age decline was different from pathological senile mania, melancholia or dementia. However, when Clouston attempted to account for this difference, he found that he could not, claiming: ‘Dotage [physiological senility] must be reckoned as natural at the end of life. It is not actually the same as senile dementia, but there is no scientific difference’.<sup>234</sup> Thus, he continued to insist on a categorical difference between natural senility and senile dementia, but could not fully explain the nature of this difference. By ‘no scientific difference’, Clouston presumably meant no *material* difference; senile dementia and senile dotage were produced by the same structural changes, but differed in ‘intensity’. The normal senility of dotage thus differed quantitatively from senile dementia. As Crichton Browne put it, in far less torturous terms, ‘dotage is simply senile dementia in a mild form, and senile dementia is advanced dotage’.<sup>235</sup>

At some point then, normal senility intensified to the point that it crossed the boundary of the physiological, to become a pathological form of insanity. The precise location of that boundary, however, was almost impossible to discern. As Bevan Lewis put it:

Were we to attempt to define the boundary betwixt the physiological and pathological form of senility, between the ordinary second childishness of old age, and the dementia resulting from the senile atrophy of disease, we should find the task a difficult if not an impossible one. No such limit exists; the one form passes by such gradations into the other, that it is, at times, impossible to say that the physiological retrogression has

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<sup>234</sup> Clouston, *Clinical Lectures on Mental Diseases*, p. 589.

<sup>235</sup> Crichton Browne, ‘Clinical Lectures On Mental And Cerebral Diseases: - V. Senile Dementia’, p. 601.

been respected, and that the symptoms imply no genuine pathological change.<sup>236</sup>

Clouston, Bevan Lewis and Crichton Browne's statements echo the conception of the normal and the pathological described by French historian and philosopher of the life sciences, Georges Canguilhem. He argues that, in the nineteenth century, the relationship between health and illness was reconfigured. Previously, health and illness had been viewed as 'qualitatively' different states, different in kind, and diametrically opposed, like Good and Evil. However, he argued that the desire of modern man to master nature and himself encouraged an 'identity' between the pathological and the physiological, which came to be viewed as quantitative variations of the same underlying processes. Health thus became 'normality', and disease became a quantitative variation from that norm.<sup>237</sup> This did not, however, remove the distinction between the two; health and illness, Canguilhem suggests, continued to be qualitatively differentiated, as they were still experienced as opposing states.<sup>238</sup> Thus, Clouston and Bevan Lewis insisted that they could discern the difference between normal senility and pathological dementia, even though they understood them to be variants of the same process. In other words, they suggested that senility and dementia were structurally identical, but qualitatively different. However, as Canguilhem himself recognised, and as French medical ethicists Daniel Dreuil and Daniel Boury have expanded on, this model of the normal and pathological is insufficient to fully account for the problems of ageing.<sup>239</sup> The normal, physiological status of old-age decay is to an extent self-evident, but far from assured. Ageing is an apparently normal phenomenon which limits activity, causes suffering, and leads inescapably to death. Our experience, then, tells us that the state of old age – even physiological old age – already differs qualitatively from

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<sup>236</sup> Bevan Lewis, *A Text-Book of Mental Diseases*, p. 413.

<sup>237</sup> Georges Canguilhem, *The Normal and the Pathological* (New York, 1989), pp. 41-43, 102-3.

<sup>238</sup> *Ibid.*, p. 56; Victoria Margee, 'Normal and Abnormal: Georges Canguilhem and the Question of Mental Pathology', *Philosophy, Psychiatry, & Psychology*, 9 (2002), p. 302.

<sup>239</sup> D. Dreuil and D. Boury, 'Autour du Vieillissement: le Normal, le Pathologique et le Fragile. Actualité de Georges Canguilhem', *Éthique & Santé*, 7 (2010), pp. 39-40.

a state of normal health. Old age thus exists in a realm somewhere between the physiological and the pathological: an 'intermediate step between life and death'.<sup>240</sup>

The structural identity of dementia and ageing thus rendered a distinction between them almost untenable. Indeed, Charles Mercier, who was particularly insistent that ageing and dementia constituted identical processes of psycho-physiological dissolution, did away with the distinction between normal and pathological senility. For Mercier, senile dementia was 'the natural condition of man in his declining years'.<sup>241</sup> He described dementia, along with sleep and intoxication, as a 'wholly normal phenomenon', though one which 'exhibit[s] an unmistakeable kinship to insanity'.<sup>242</sup> Indeed, as described in the first section of this chapter, Mercier understood dementia at any age to be a rendition of the normal ageing process, which 'may set in earlier in life, if the life have been subject to severe drain upon its energies [sic]'.<sup>243</sup> Similarly, in his 1906 classification of mental diseases, Joseph Bolton suggested that all dementia were 'examples of natural involution of the cortical neurones'.<sup>244</sup> Dementia, then, was pathological in youth, but merely a 'natural involution' in old age.

Thus, by the beginning of the twentieth century, the boundary between natural senility and pathological dementia – between 'simple forgetfulness and its more malignant form', in Holstein's terms – had almost entirely collapsed. Yet the manner in which those phenomena were conflated was more tortuous, and more ambivalent, than Holstein's characterisation suggests. In 1908, in the latest textbook included in this study, William H. Stoddart wrote that 'the normal mental deterioration of old age is itself early senile dementia', but that the location of the line between the former and the latter was 'the question that cannot be answered'.<sup>245</sup> In practice, however, firmer lines needed to be drawn. When it came to the determination of whether an older person was insane enough to deserve admission

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<sup>240</sup> Dreuil and Boury, 'Autour du vieillissement', p. 40.

<sup>241</sup> Mercier, *Sanity and Insanity*, p. 370.

<sup>242</sup> *Ibid.*, pp. 298-99.

<sup>243</sup> *Ibid.*, p. 371.

<sup>244</sup> Bolton, 'Amentia and Dementia', p. 429.

<sup>245</sup> Stoddart, *Mind and Its Disorders*, p. 340.

to a lunatic asylum, the question of the line between natural senility and senile dementia became a political one: the answer could dictate which institution should take responsibility for this small but difficult population. As the next chapter will argue, pressures on the asylum, at a national and local level, made it politically expedient for psychiatrists, in their role as asylum superintendents, along with the Lunacy Commissioners and individual asylum managers, to advance a definition of old-age mental disorder which emphasised its inevitable, natural, and essentially harmless nature.

## Chapter Two: The Politics of Lunacy and the Exclusion of Senility

The ambiguities discussed in Chapter One were largely flattened in the administrative discourse surrounding the provision of care for the insane. Here, more than anywhere else, a 'senile' patient emerged who was clearly defined: decrepit, incurable, and naturally deteriorating rather than pathologically insane. While Chapter One examined theoretical definitions of insanity and senility, this chapter will begin to discuss *working* definitions, forged through the classification and organisation of the insane population. This chapter, then, is about the politics of welfare: who decides which institution should take responsibility for a certain dependent group? How is this decision justified? What effects does it have? In his lectures on *Psychiatric Power*, Michel Foucault described the way that disciplinary institutions – institutions which rely on and enforce normativity – create 'residual' groups. These are made up of people who did not conform to the norms of any institution: 'the irreducible, the unclassifiable, the inassimilable'. These failures in classification, according to Foucault, produce new categories of people.<sup>1</sup> This chapter will suggest that, in the latter part of the nineteenth century, the senile emerged as one of these residual groups: too behaviourally difficult for the workhouse, too aged and decrepit for the asylum, and too marginal and unpromising to be given a normative institution of their own.

The increase in insanity – the unceasing growth in the number of people officially recognised as insane over the course of the nineteenth century – is a well-documented phenomenon.<sup>2</sup> As the county lunatic asylums became ever more crowded and miserable in the second half of the nineteenth century, the administrators of lunacy at a national and local level sought explanations for the

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<sup>1</sup> Michel Foucault and Jacques Lagrange, *Psychiatric Power: Lectures at the Collège de France, 1973-74* (Basingstoke, 2006), p. 53.

<sup>2</sup> John K. Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848-50', *Journal of Social History*, 13 (1979), p. 2; Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (New Haven, 1993), pp. 26-30; E. Hare, 'Was Insanity on the Increase? The Fifty-Sixth Maudsley Lecture', *The British Journal of Psychiatry*, 142 (1983), pp. 439-55; Andrew Scull, 'Was insanity increasing? A response to Edward Hare', *The British Journal of Psychiatry* 144 (1994), pp. 432-36.



apparent failure of the asylums project. The asylum population came to be viewed in terms of 'desirable and undesirable' cases, and the aged and senile fell decisively into the latter category.<sup>3</sup> The people who managed and oversaw the care and treatment of lunatics accused intolerant families and parsimonious Poor Law officials of offloading unsuitable cases onto the asylum and, in doing so, with expanding the meaning of certifiable insanity. The administrators of lunacy responded by asserting their own, restricted, definitions of insanity and senility. They described the senile as a group whose mental infirmity was incurable, manageable and, crucially, natural. This, they argued, unambiguously excluded them from a claim to asylum care. This chapter examines the emergence and impact of this exclusionary discourse of senility.

This discursive exclusion was extended to, and reinforced by, attempts to physically exclude old people from institutions dedicated to the care and cure of insanity. The senile were a perpetual classificatory residuum: too weak and unresponsive to adhere to the norms of the asylum regime, yet too challenging in their behaviour to conform to that of the workhouse, and too dependent and devoid of promise to be classified with trainable 'imbeciles'. Aged and infirm patients were described as a problem to be solved, or an encumbrance to be rid of, but rarely as a group whose particular needs should be catered for. The case of the senile highlights a contradiction at the heart of nineteenth-century welfare policy and rhetoric: a group which embodied the 'deserving poor' in almost every way – old, incapable, and mentally troubled – was one for which no public institution was prepared to take unequivocal responsibility.

The final irony shown in this chapter is that the exclusion of the senile ultimately failed. Despite repeated attempts to deny responsibility for them, senile, aged, demented cases continued to arrive at the gates of the asylum, and long-term cases continued to age and die within their walls. The asylum demonstrably provided a useful resource for families and communities in their attempts to deal with old-age mental illness. But by casting the presence of the senile as an

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<sup>3</sup>Elaine Murphy, 'The Lunacy Commissioners and the East London Guardians, 1845-1867', *Medical History*, 46 (2002), p. 512-13.

aberration, rather than a fact of asylum life, the administrators of lunacy could continue to present the asylum as an institution whose potential was being thwarted, rather than one which was fundamentally flawed.

This chapter begins with an examination of this discussion at a national level, particularly as it played out in the annual reports of the Lunacy Commissioners.<sup>4</sup> This first section of the chapter will also draw on comments made by individual psychiatrists – many of whom appeared in Chapter One – in national medical publications. The chapter will then move on to look at how the managers of two asylums, Hanwell and Caterham, imagined and dealt with the issue of aged admissions. Hanwell was a county lunatic asylum, while Caterham was an imbecile asylum, run by the MAB. Their objections – and responses – to the problem of senile admissions, are examined in the second and third sections of this chapter.

Although they often disagreed significantly, all of these groups – the Lunacy Commissioners, the asylum physicians who published their complaints in the *Journal of Mental Science*, and the managers and medical officers of Hanwell and Caterham asylums – will at times be collectively referred to as the administrators of lunacy. This is to differentiate them from the group they maligned in these discussions: the administrators of the Poor Law. This other group includes workhouse medical officers and other officials, Poor Law Guardians, and the national Poor Law Board (after 1871, the Local Government Board). They, unsurprisingly, took a rather different view of the suitability of senile patients for

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<sup>4</sup> Established by the 1845 Lunacy Act, the Lunacy Commissioners' main responsibility was inspecting all institutions – public and private – which housed a certified lunatic, and reporting their findings in an annual report. In the 1980s, historian Nicholas Harvey influentially interpreted the Lunacy Commission as an essentially impotent institution, with no genuine political power. More recently Peter Bartlett has suggested that, although the Commissioners were in a 'position of administrative and political weakness', they were able to influence the management of asylums by local Justices 'incrementally', largely through persuasion and through the intercession of the Poor Law Board. N. Harvey, 'A Slavish Bowing Down: the Lunacy Commissioners and the Psychiatric Profession, 1845-60', in William F. Bynum, Roy Porter and Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. II* (London, 1985), pp. 98-131; Peter Bartlett, *The Poor Law of Lunacy: the Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London, 1999), pp. 197-237. For a local example of the Commissioners' influence, see Joseph Melling and Bill Forsythe, *The Politics of Madness: the State, Insanity and Society in England, 1845-1914* (London, 2006), pp. 197-237.

asylum care. That being said, they too participated in the exclusionary discourse of senility, being as unwilling as asylum managers to take responsibility for disruptive or difficult old people. The final section of this chapter will examine this alternative view of the senile problem, from the workhouse.

### **The Lunacy Commissioners, Incurables and the Senile**

Contemporary and historiographical accounts of the Victorian asylum are haunted by an ill-defined, yet inescapable, class of problematic patients. This so-called 'incurable residue' was a heterogeneous group – consisting of 'harmless imbeciles', idiots and epileptics, demented persons, and 'those labouring under chronic insanity' – but it constituted a unified threat.<sup>5</sup> Incurable patients were described as a drain on asylum resources, blocking beds that could be used for more promising cases, and undermining the legitimacy of the asylum as a curative institution.<sup>6</sup>

Leonard Smith has suggested that this group was identified as a problem as early as the 1820s, when asylum Superintendents came 'increasingly to lament the accumulation of hopeless and "incurable" patients'.<sup>7</sup> In 1858, in one of the earliest editions of the *Journal of Mental Science*, editor John Charles Bucknill complained that the wrong people often made it to the asylum: quiet, curable cases of mania and melancholia stayed in the workhouse, while 'troublesome' but incurable epileptics and senile demented were removed.<sup>8</sup> The problem of the incurables was thus a part of the professional, asylum-based discourse of psychiatry from its inception.

The Lunacy Commissioners first referred to the increase of insanity in their report of 1855.<sup>9</sup> As concern about this issue grew in subsequent decades, the

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<sup>5</sup> *The Twenty-Seventh Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1873), p. 18.

<sup>6</sup> P. McCandless, '"Build! build!" the Controversy Over the Care of the Chronically Insane in England, 1855-1870', *Bulletin of the History of Medicine*, 53 (1979), p. 555; L. J. Ray, 'Models of Madness in Victorian Asylum Practice', *European Journal of Sociology*, pp. 229-64; Scull, *Most Solitary of Afflictions*, pp. 371-72.

<sup>7</sup> Leonard Smith, *Cure, Comfort, and Safe Custody: Public Lunatic Asylums in Early Nineteenth Century England* (London, 1999), p. 113.

<sup>8</sup> John Charles Bucknill, 'The Custody of the Insane Poor', *Journal of Mental Science* (April, 1858), pp. 460-72.

<sup>9</sup> *The Ninth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1855), pp. 32-36.

volume and nature of complaints about the incurable residue intensified. It was common, from the 1870s onwards, for the Lunacy Commissioners and *JMS* contributors alike to complain of the 'altered character' of asylum admissions, with bodily infirmity on the rise and curability diminishing.<sup>10</sup> Year after year, the Commissioners reported a substantial worsening in the problem which, by the turn of the century, was said to have 'much accelerated'.<sup>11</sup> Taken as a whole, the Lunacy Commissioners' reports give the impression of an entire nation of county asylums groaning under the weight of an immovable but harmless resident population, while they repeated the same statements of objection in an ineffectual attempt to defend themselves against a ceaseless barrage of yet more benign, decrepit, incurable patients.

Incurable people, it was argued, did not *need* asylum treatment, 'requiring little medical skill in respect to [their] mental disease', yet they took away resources from curable lunatics who might actually benefit from the costly facilities an asylum could offer.<sup>12</sup> Thus, incurable lunatics represented a present and future burden: wasting expensive asylum care now, and keeping it from those who, without swift intervention, might also join their incurable ranks. As the problem of asylum overcrowding worsened, and the number of recorded lunatics continued to increase, focus intensified on incurable lunatics as the cause of the asylums' problems. Moreover, the presence of incurables in the asylum was offered as proof that the increase of insanity was a mere statistical artefact – 'only a multiplication of numbers' – rather than an epidemiological trend.<sup>13</sup> The paradox of the county asylums – the fact that the proliferation of supposedly curative institutions had apparently led to a marked increase in insanity – threatened seriously to undermine the asylum project, and the authority of the Lunacy Commissioners and asylum

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<sup>10</sup> See for example *The Twenty-Seventh Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1873), p. 18; *The Thirtieth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1876), p. 13; *The Thirty-Second Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1878), pp. 39-40; *The Thirty-Fourth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1880), pp. 116-17.

<sup>11</sup> *The Fifty-Fifth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1901), p. 8.

<sup>12</sup> *The Eleventh Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1857), p. 12; *The Twenty-First Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1867), p. 67.

<sup>13</sup> *Special Report of the Commissioners in Lunacy to the Lord Chancellor on the Alleged Increase of Insanity*. (1897), pp. 2, 26-28.

doctors alike.<sup>14</sup> By focussing their complaints on an intractable 'incurable class', the administrators of lunacy could deflect the blame onto those who had 'wrongly' sent such cases to the asylum in the first place, and onto the patients themselves. Increasingly, incurability was portrayed, not as a state into which patients might fall, but as an essential feature of certain patients. Incurables were thus framed less as an indictment of the asylum's status as a curative institution, but more as an externally-induced barrier to the fulfilment of its curative potential.

The aged were doubly implicated in this incurable class: a lunatic who proved incurable would remain insane, and in the asylum, into their old age, while insanity which first appeared in old age was generally considered to be inherently incurable. In the late-nineteenth century, aged and senile patients began to emerge in this administrative discourse as a problem group in their own right. In the 1870s, the Commissioners began to bring back concerned reports from the asylum visitations, commenting on the high numbers of aged patients resident in, and being sent to, county asylums.<sup>15</sup> In 1880, these concerns finally made their way into the main report. 'In many instances,' they wrote, 'an inclination exists to send off to an Asylum old chronic cases, because they are a little troublesome and difficult to manage.'<sup>16</sup> In this statement, no distinction is made between those who were aged because they were incurable, or incurable because they were aged. Increasingly, however, *senile* admissions – those whose mental infirmity was a product of their age specifically – were singled out as inappropriate cases, and as a serious impediment, a danger even, to the functioning of the asylum. In 1881, the Commissioners described the admission of a large number of 'old feeble people

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<sup>14</sup> Vieda Skultans, *English Madness: Ideas on Insanity, 1580-1890* (London, 1979), pp. 118-19.

<sup>15</sup> See for example *The Twenty-Fifth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1871), pp. 130, 144; *The Twenty-Eighth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1874), pp. 208-186; *The Twenty-Ninth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1875), pp. 181-82.

<sup>16</sup> *The Thirty-Fourth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1880), pp. 116-17.

whose unsoundness of mind arises, not from any active form of insanity, but from natural decay', as an 'evil'.<sup>17</sup>

### *The Enumeration of Senility*

In the 1890s, and into the twentieth century, the Commissioners' concerns about the phenomenon of aged asylum admissions became more intense, and more statistically-oriented.<sup>18</sup> They were committed contributors to the so-called 'avalanche of printed numbers' and, in keeping with the late-nineteenth-century enthusiasm for social data as a means of solving social problems, looked to these numbers as an authoritative means to test (and legitimise) their opinions. A lasting consequence of these 'enumeration practices' more broadly was the creation and reification of different categories of people.<sup>19</sup> Historians of old age, such as Stephen Katz and Karen Chase, have argued that 'old age' was one such category; 'the aged' became a more clearly-defined and knowable section of society in late-nineteenth-century Britain, partly through data-gathering activities such as Charles Booth's social surveys.<sup>20</sup> The greater emphasis on statistics also brought a new urgency to the difficult questions surrounding the definition of insanity: who should count as a lunatic?

In 1895, the Commissioners turned their statistical investigations towards the problem of aged asylum admissions specifically. They did not collect any new data, but examined the returns of the county asylums from the preceding 30 years,

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<sup>17</sup> *The Thirty-Fifth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1881), p. 264.

<sup>18</sup> The Commissioners collected their statistics by collating information from the census and from individual asylum reports, and by sending out their own returns to be filled in by asylum doctors and managers. They began to publish these numbers in tabular form in 1869, starting with general statistical tables showing the geographical and institutional distribution of all the lunatics in the country, and overall rates of admission, discharge and death. In the late 1870s, they began to interrogate these large numbers more closely, adding smaller categories to their analyses, such as marital status and occupation. By 1904 there were over 50 tables appended to the Lunacy Commissioners' annual reports, covering diverse phenomena from the forms of disorder suffered by each registered lunatic in the country, to rates of diarrhoea in the county asylums. *The Twenty-Third Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1869), pp. 1-10; *The Fifty-Eighth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1904), pp. 2-16.

<sup>19</sup> Ian Hacking, 'Biopower and the Avalanche of Printed Numbers', *Humanities in Society*, 5 (1982), pp. 279-95.

<sup>20</sup> Stephen Katz, *Disciplining Old Age: the Formation of Gerontological Knowledge* (Charlottesville, 1996), p. 73; Karen Chase, *The Victorians and Old Age* (Oxford, 2009), pp. 240-47.

in order to 'test...by figures' the opinion that the increase in insanity was due 'in part to the reception in recent years of more cases of mental decay arising solely from old age'. They concluded that there had been a 'gradual, but continuous advance', disproportionate to the overall increase in insanity, in the number of asylum patients aged 60 or over who were being admitted annually to the county asylums of England and Wales. They also claimed that there had been an increase in the number of patients whose insanity was attributed to their old age.<sup>21</sup> The Commissioners' decision to statistically investigate the admission of patients over a certain age – without any inquiry into their mental condition or physical health – both reflected and reinforced the tendency to see age alone as grounds upon which to question an individual's claim to asylum care. Over the next 15 years, the Commissioners continued to regularly remark upon the proportion of aged patients being sent to the asylum which, according to their statistics, was steadily increasing. This further fuelled the exclusionary discourse of senility.

The question of whether there actually *was* an increase in aged asylum admissions remains unclear. The few historical studies to address this question have concluded that there was no significant increase in the number of elderly admissions to the asylum in the second half of the nineteenth century.<sup>22</sup> The officially published statistics of Hanwell, however, do suggest an increase in both the number of patients aged 60 or over admitted, and the proportion of the overall number of admissions that these older patients represented. Figure 4, below, shows that patients aged 60 or over only ever made up a small proportion of Hanwell's annual admissions, and suggests that the fluctuations in the number of aged admissions mirrored the fluctuation in the number of admissions as a whole. The number of aged patients admitted to Hanwell began to increase in the 1860s, and then increased significantly again in the 1890s. Figure 5 gives a more detailed picture, showing the percentage of the total admissions who were aged 60 or over

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<sup>21</sup> *The Forty-Ninth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1895), pp. 3-4.

<sup>22</sup> J. L. Crammer, *Asylum History: Buckinghamshire County Pauper Lunatic Asylum--St. John's* (London, 1990), pp. 117-22; Graeme Yorston and Camilla Haw, 'Old and Mad in Victorian Oxford: a Study of Patients Aged 60 and Over Admitted to the Warneford and Littlemore Asylums in the Nineteenth Century', *History of Psychiatry*, 16 (2005), p. 401.

during this period. It shows that, prior to 1865, the proportion of admissions aged 60 or above was generally below 10 per cent. Between 1865 and 1880, the proportion stayed around 10 per cent, before moving towards and above 15 per cent at the turn of the century.<sup>23</sup> The Hanwell statistics, then, generally support the Commissioners' claim, that there was an increase in aged admissions over this period. In any case, the most important issue for this chapter is not whether or not the Commissioners were justified in their conviction that the number of aged admissions was increasing, but the effect that this conviction had on their attitude towards aged patients.

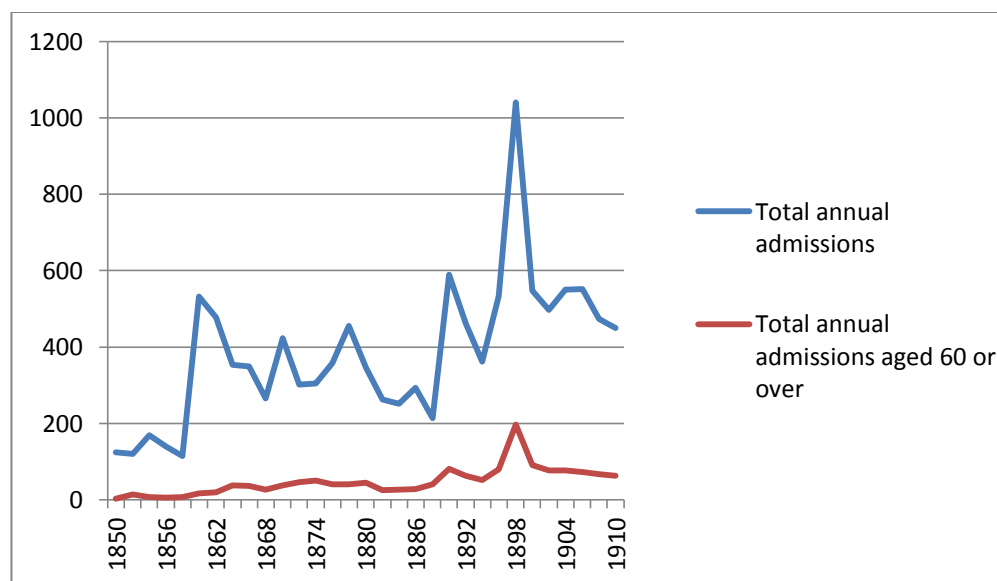


Figure 4. Annual admissions to Hanwell Asylum, 1850-1910. Figures taken from *Annual Reports of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1850-1888) and *The Annual Report of the [London County Council] Asylums Committee and the Sub-committees of [various] asylums* (1889-1911).

<sup>23</sup> A contemporary study of the national lunacy statistics also concluded that there had been a 'marked increase' in the number of aged patients being admitted to England and Wales' lunacy statistics which, the writer (former registrar-general of the post office, not a psychiatrist) concluded indicated 'an increased tendency to transfer cases of senile dementia' from workhouses to asylums. Noel A. Humphreys, 'The Alleged Increase of Insanity', *Journal of the Royal Statistical Society*, 70 (1907), pp. 218-20, 229.



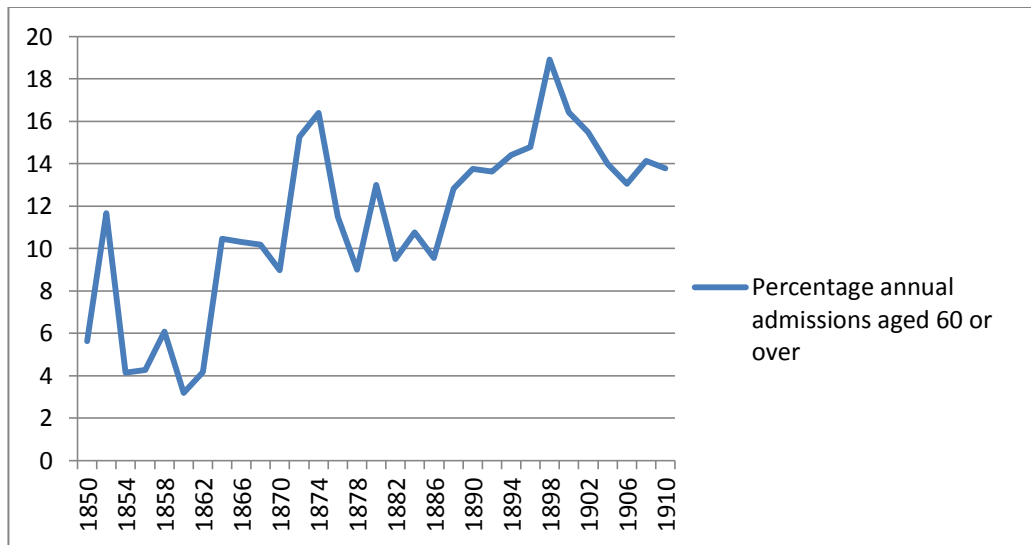


Figure 5. The proportion of annual admissions to Hanwell Asylum reported to be aged 60 or over on admission, 1850-1910. Figures taken from *Annual Reports of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1850-1888) and *The Annual Report of the [London County Council] Asylums Committee and the Sub-committees of [various] asylums* (1889-1911).

### *Explaining the Increase: the Four-Shilling Grant*

As with the increase in insanity generally, the administrators of lunacy rejected the suggestion that old people were becoming genuinely more susceptible to mental infirmity. If more old people were arriving at the asylum, they argued, it was because people were becoming more inclined to send them. Recognising that it was families and workhouse officials who identified potential asylum cases and secured their admission, the Commissioners pointed to a decreasing willingness to tolerate and care for those who were 'troublesome from senile dementia, [and] dirty in [their] habits'. 'A change of feeling has undoubtedly occurred in the poorer classes', they reported in 1894, 'which now leads them, without reluctance, to see placed in asylums insane and mentally worn-out members of their families whom they would formerly have retained in their homes'.<sup>24</sup> It was the workhouse officials who received the bulk of the Commissioners' ire, for using the asylum to ease their own burdens. After 1867, they could point to alterations in asylum funding practices to explain the apparent change in workhouse officials' attitudes and actions.

<sup>24</sup> *The Forty-Eighth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1894), p. 6.

Under the Metropolitan Poor Act of 1867, a Common Poor Fund was set up in London which centralised the provision of funding for care of insane (and infectious) paupers outside of the workhouse, spreading the cost of payment amongst the vastly unequal London Unions.<sup>25</sup> In 1874, a national four-shilling grant was introduced which extended this principle to the rest of the county. The four-shilling grant was paid to Poor Law Unions for each of their chargeable paupers who were housed in an asylum. It came from a centrally-collected fund, thus partially relieving local rate-payers of the expense of maintaining asylum lunatics. In 1876, the Commissioners first raised a concern that the 'pecuniary advantage' offered to Unions by the four-shilling grant may be encouraging them to send larger numbers of paupers to the asylum, thus contributing to the increase in Lunacy that year.<sup>26</sup> In the decades to follow, the Commissioners displayed an unwavering conviction that the four-shilling grant had given fiscally-motivated Guardians an excuse to offload any slightly troublesome workhouse inmates onto the asylum. It was cited as a cause of almost all of the asylums' problems, including the continued presence of aged, senile patients.

Some historians have agreed that these financial incentives contributed significantly to the increase of incurable lunacy in the asylum.<sup>27</sup> 'No wonder', writes Elaine Murphy, 'the rate of "insanity" rose dramatically in London over the next few years'.<sup>28</sup> While the logic of this argument seems compelling – overstretched workhouse officials were being given the opportunity to relieve themselves of a financial and practical burden – it has not always stood up to more detailed scrutiny. Robert Ellis, in a case study of two county asylums, has concluded that there is little evidence that this particular administrative change

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<sup>25</sup> David R. Green, *Pauper Capital: London and the Poor Law, 1790-1870* (Farnham, 2010), pp. 238-39.

<sup>26</sup> *The Thirtieth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1876), p. 3.

<sup>27</sup> Kathleen Jones, *Asylums and After: a Revised History of the Mental Health Services from the Early 18th Century to the 1990s* (London, 1993), pp. 115-17.

<sup>28</sup> Elaine Murphy, 'The Lunacy Commissioners and the East London Guardians', p. 520. David Cochrane similarly suggested that the Metropolitan Poor Act largely accounted for the particularly high volume of asylum admissions in London: David Cochrane, "'Humane, Economical and Medically Wise": The LCC as Administrators of Victorian Lunacy Policy', in William F. Bynum and Roy Porter (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. III* (London, 1988), pp. 251-52.

made any recognisable difference to the rates of chronic lunatics admitted to the asylum. He argues, therefore, that it was simply a 'hackneyed' feature of the Commissioners' and asylum officers' rhetoric, which absolved them of responsibility for the worsening conditions of the county asylums.<sup>29</sup> It should be noted that Ellis only counted 'chronic' patients who were recorded to have been insane for at least twelve months prior to admission.<sup>30</sup> While aged patients were generally considered chronic, in that they would never recover, and had often been displaying symptoms of mental disturbance for several months or years before their asylum admission, they would not all have fitted into the category of 'chronic lunatic' as Ellis defined it. Hanwell's official statistics show an increase in aged admissions at the beginning of the 1870s (see Figure 4, above), which may have been stimulated by the Common Poor Fund. A similar effect cannot be detected, however, following the introduction of the four-shilling grant. The London case was complicated, of course, by the opening of Caterham and Leavesden Imbecile Asylums, which potentially took in a number of cases who may have otherwise gone to Hanwell.

Certainly, not all contemporary observers agreed on the effect of the grant. Unsurprisingly, workhouse officials denied that it had induced them to act improperly in their own interests. At the Royal Commission on the Poor Laws and the Relief of Distress, the familiar accusations – that senile demented were sent from the workhouse to the asylum purely for the sake of the money, and to save the officers some trouble – were put directly to John Mott, Chair of the Fulham Guardians. He answered that he was 'sure' that such considerations never entered into the decision to seek certification for an older patient: 'It is quite true that a number of aged persons go from the workhouse to the asylums,' he stated, 'but that is not because of the four-shilling grant; it is because they are almost intolerable in

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<sup>29</sup> Robert Ellis, 'The Asylum, the Poor Law, and a Reassessment of the Four-Shilling Grant: Admissions to the County Asylums of Yorkshire in the Nineteenth Century', *Social History of Medicine*, 19 (2006), pp. 55-71.

<sup>30</sup> *Ibid.*, p. 64. Edgar Miller also concluded that the four-shilling grant made little appreciable difference to the steadily increasing rates of insanity. Edgar Miller, 'Variations in the Official Prevalence and Disposal of the Insane in England under the Poor Law, 1850-1900', *History of Psychiatry* 18 (2007), pp. 25-38.

the workhouse'.<sup>31</sup> This feature of workhouse officers' rhetoric will be examined at the end of the chapter.

### *The Meaning of Insanity and the Exclusionary Discourse of Senility*

According to some asylum doctors and administrators, the four-shilling grant actively contributed to an expansion in the meaning of lunacy. With the promise of extra funding for asylum cases, Poor Law medical officers were encouraged, they claimed, to certify patients who would never previously have been considered insane. In 1877 Henry Maudsley wrote that, because of the grant, 'Parish and workhouse officers willingly saw lunacy in forms of imbecility and illness in which they would never have dreamt at one time of doing so'.<sup>32</sup> In his annual report for 1886, Thomas Clouston responded to the suggestion that the increase in admissions of patients over 60 at Morningside Asylum was caused by a general increase in mental deficiency in the aged population: 'This would be fallacious. We believe that more people in their restless and troublesome dotage... are now sent to asylums, and so come under the category of technical insanity, than formerly.'<sup>33</sup> These leading lights of the psychiatric profession, along with the Lunacy Commissioners, perceived an expansion in the range of behaviours and afflictions being categorised as 'insanity', as both a cause *and* a consequence of the growing tendency to send aged cases to the asylum. A classificatory re-ordering was going on, they claimed, but it was driven by agents external to the asylum.

The historical record calls into question the validity of this assessment. The determination of who was and was not a suitable case for asylum care had never been straightforward, and neither asylum doctors nor the Lunacy Commissioners had always acted as strict gatekeepers of a firmly limited set of admission criteria. The inclusive approach of the early lunacy reformers towards their target population forms an important part of Andrew Scull's thesis on the rise of the

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<sup>31</sup> *Royal Commission on the Poor Laws and Relief of Distress. Appendix Volume I. Minutes of Evidence (1st to 34th days) Being Mainly the Evidence Given by the Officers of the Local Government Board for England and Wales*, (Cd. 4625, 1909), p. 620.

<sup>32</sup> Henry Maudsley, 'The Alleged Increase of Insanity', *Journal of Mental Science* (April, 1877), p. 51.

<sup>33</sup> Thomas Clouston, 'Decrease of General Paralysis, and Increase of Insanity at Advanced Ages, In Edinburgh', *British Medical Journal*, 1 (1886), p. 901.

asylum. Faced with the ambiguous boundary between sanity and insanity, he argues, psychiatrists and lunacy reformers were driven by a belief in the humanitarian benefits of their project, and by professional self-interest, to pursue a policy of 'incorporation rather than exclusion'.<sup>34</sup> In other words, they were prepared to adopt a broad definition of insanity. Though he has been criticised for placing too much emphasis on the power of professionally imperialist psychiatrists, Scull recognised that the real agents in the committal process, and thus in shaping the practical definition of insanity, were those outside the asylum walls: 'it was the lay conception of what was and was not behaviour which could be borne which fixed the boundary between sane and insane.'<sup>35</sup> Families and workhouse officials, then, were complicit in maintaining an inclusive definition of lunacy, originally fostered by the early lunacy reformers. The case of the aged in the asylum is supportive of, and illuminated by, this idea. In order to enter the asylum, a patient had to be officially certified as a 'lunatic'. Thus, when families and Poor Law officials chose to send their troublesome old people there, they were enacting the belief that an old person could be a lunatic, and that senility could be a form of insanity. Whether or not they had envisaged a situation in which old people would be a significant presence on asylum wards, the early lunacy reformers had demonstrably created an atmosphere in which Poor Law officials felt justified in sending to the asylum cases of 'restless and troublesome dotage'.

Legally, Poor Law officials were quite within their rights to send such cases to the asylum, as the Commissioners themselves had once been at pains to point out. Far from expanding the meaning of 'technical insanity' beyond its legal limits, it was the workhouse officials who seemed to be adhering to the spirit of the law. There were three categories in the legal language of insanity: 'idiot', for a person with a permanently 'deficient mind' from birth; 'lunatic', for those who were only sometimes *non compos mentis*; and 'person of unsound mind', for someone who was

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<sup>34</sup> Scull, *Most Solitary of Afflictions*, p. 380.

<sup>35</sup> H. Freeman, 'Psychiatry in Britain, c. 1900', *History of Psychiatry*, 21 (2010), p. 313; J. L. Crammer, 'English Asylums and English doctors: Where Scull is Wrong', *History of Psychiatry*, 5 (1994), pp. 103-115; Scull, *Most Solitary of Afflictions*, pp. 350-51.

'incapable of managing his affairs... a person of weak mind'.<sup>36</sup> According to these criteria, the senile were encompassed under the latter category, and were unambiguously separated from the category of 'lunatic'. The 1845 Lunacy Act, however, did not mobilise these distinctions in any meaningful way and, for the rest of the century, these categories continued to be used fluidly. Both 'lunatic' and 'of unsound mind' were used as umbrella terms for all three of these categories. Following some confusion in a trial in 1848 over the legality of confining a non-dangerous lunatic, the Lunacy Commissioners wrote a clarifying letter to the Lord Chancellor, stating,

It is of vital importance that no mistake or misconception should exist... that, according to law, any person of unsound mind, whether he be pronounced dangerous or not, may legally and properly be placed in a county asylum, lunatic hospital or licenced house.

This rendered the tripartite division essentially meaningless. In their annual report of the same year, the Commissioners complained that the current estimation of the number of people 'of unsound mind' in the country was almost certainly too low, as it did not yet include those "'Imbecile" persons, having been so from birth, or become so from senility.' Such persons, they argued, although not requiring the same treatment as other lunatics, were 'incapable of managing their affairs in an efficient manner'. Thus, they required 'in effect nearly the same protection... as ordinary Lunatics, and should therefore properly be included in any estimate of the number of persons of Unsound Mind'.<sup>37</sup>

This would suggest that it was the administrators of lunacy, and not the Poor Law officials, who were seeking to change the *status quo* in the latter part of the nineteenth century, by defining certain groups as *unsuitable* for asylum care. Guardians and families were not seeking to expand the definition of insanity, as

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<sup>36</sup> Charles Palmer Phillips, *The Law Concerning Lunatics, Idiots and Persons of Unsound Mind* (London, 1858), pp. 1-2, as quoted in David Wright, *Mental Disability in Victorian England: the Earlswood Asylum, 1847-1901* (Oxford, 2001), pp.15-16.

<sup>37</sup> *The Second Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1847-8), p. 54.

Maudsley and Clouston claimed, lunacy administrators were in fact seeking to *limit* it. Elaine Murphy has suggested something like this, in her work on the workhouse care of lunatics in mid-nineteenth-century East London. For Murphy, the 1862 Lunacy Act - which gave statutory legitimacy to the practice of removing incurable cases from the asylum to the workhouse – was a decisive moment. She argues that the 1862 Act saw the Commissioners abandon their project to see *all* lunatics confined under their jurisdiction, and relinquish their commitment to care for anyone who was mentally disturbed. Thus, the 1862 Act represented a significant break from the inclusive terms of the 1845 Act, one that sprang from a new recognition that ‘insane persons came in desirable and undesirable forms’.<sup>38</sup> This was matched by a broader commitment on the part of the Lunacy Commissioners to attempt to exclude ‘undesirable’ lunatics – including the senile – from the asylum.

The ambiguity surrounding the pathological status of senility allowed the administrators of lunacy to reject the claim of aged patients to asylum care on grounds that they were not, in fact, insane. Thus, from the 1870s onwards, the Commissioners frequently undermined the legitimacy and severity of old-age mental infirmity with references to ‘*mere* senile dementia’.<sup>39</sup> Increasingly, they complained about ‘aged persons who are not properly lunatics, but suffering only, or principally, from the decay of faculties incident to old age’.<sup>40</sup> This represented a significant shift in the Commissioners’ attitude and approach. Although the lunacy reforms of the 1840s explicitly stated that unsoundness of mind arising from natural decay *should* be counted as a form of lunacy, the later administrators of lunacy continually invoked the ‘naturalness’ of senility as a way of discrediting their claim to asylum treatment. The Commissioners of 1848 had stated that any accurate count of the number of paupers who were unsound of mind *must* include those who had been rendered so by senility. The Commissioners of 1884 took the

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<sup>38</sup> Murphy, ‘The Lunacy Commissioners and the East London Guardians’, pp. 512-13.

<sup>39</sup> See for example *The Twenty-Ninth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1875), pp. 181-82; *The Thirty-Eighth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1884), pp. 5-6; *The Fiftieth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1896), p. 5; *The Fifty-Eighth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1904), p. 4.

<sup>40</sup> *The Thirty-Fifth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1881), p. 236.

opposite position, decrying the practice of classifying cases of ‘mild or harmless dementia’ in such a way, arguing that, ‘To include such persons in the returns as being of unsound mind tends *unduly* to swell the statistics of insanity [emphasis mine]’.<sup>41</sup>

This suggests an extension to Scull’s thesis about the inclusive nature of the lunacy reformers’ attitude towards insanity. In the latter part of the century, faced with the reality of these cumbersome, expensive institutions, the Commissioners – and other administrators of lunacy – tried to advance a more *exclusive* definition of insanity, and to police the boundaries of insanity more strictly. In 1891, they congratulated themselves for seeing many senile workhouse patients removed from the lists of the insane.<sup>42</sup> This was a small victory. It was too late, it seems, to overhaul the established patterns in the way the asylum was used. As long as the boundary between sanity and insanity – like the boundary between natural ageing and illness – was ambiguous, the practical classification of insanity was driven by institutional needs. As will be discussed in the next chapter, it was families and Poor Law officers who drove the admissions process, and it was their needs which drove the definition of a suitable asylum case. We can see the exclusionary discourse of senility as an attempt by the administrators of lunacy to re-assert their own needs. By emphasising one particular interpretation of old-age mental debility – that it was a natural, fairly benign phenomenon, not a pathological insanity – they could justifiably reject responsibility for aged care.

### *The Commissioners’ Solution*

The previous section discussed the ways in which the Lunacy Commissioners, and other administrators of lunacy, talked about the problem of senile asylum admissions. This section will look at what they intended to do about it. As early as 1857, the Commissioners began to consider a ‘fresh classification and redistribution of patients’ to deal with the problem of the overcrowded asylum.<sup>43</sup> Though there was a cautious acceptance that some classes of lunatic might be better cared for in

<sup>41</sup> *The Thirty-Eighth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1884), pp. 5-6.

<sup>42</sup> *The Forty-Fourth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1890-1), pp. 2-3.

<sup>43</sup> *The Eleventh Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1857), p. 12.



the workhouse, in the 1850s and 60s the Commissioners' preferred solution to the problem of the chronic residuum was the creation of a middle ground; new institutions, or separate buildings within the asylum estate, 'intermediate in character between the asylum and workhouse'.<sup>44</sup> They would be suitable for patients who, though 'quiet and harmless', might still be 'unfit to be at large or placed in Workhouses'.<sup>45</sup> Most importantly, they would be cheaper than the county asylums in every way, from their construction to their administration. They would not need the 'expensive arrangements and appliances' of the general asylum, and would reflect a simpler architectural style.<sup>46</sup> The treatment of curable lunatics, it was implied, was expensive, but the care and custody of incurables need not be. As well as cheap, these asylums were also presented as potentially 'cheerful' places. They would be spacious, bright and well ventilated, and designed along more domestic lines, as small apartments or cottages, without the large dormitories which characterised the county asylum.<sup>47</sup> It seems that the Commissioners were hoping that these institutions would provide an antidote to the warehouse-like image of the county asylum which had already begun to dominate. However, the initial concern about cost proved decisive in the final design of these buildings. When Caterham and Leavesden asylums – largely inspired by these plans, despite being built under the auspices of the Poor Law Board and not the Commissioners – were built at the end of the 1860s, featureless and densely populated dormitories were their key organising principle. Elaine Murphy has described them as 'a testament to mean-spirited committee thrift'.<sup>48</sup>

The opening of Caterham and Leavesden also confounded the Commissioners' expectations of the type of patient that would enter these institutions. In 1857, at the height of the Commissioners' enthusiasm for intermediate asylums, they claimed that they would house two types of patient: the

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<sup>44</sup> *The Twenty-First Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1867), p. 61.

<sup>45</sup> *Ibid.*, p. 61.

<sup>46</sup> *The Thirteenth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1859), p. 3; *The Twenty-First Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1867), pp. 72-73.

<sup>47</sup> *The Thirteenth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1859), p. 3; *The Twenty-First Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1867), pp. 72-73.

<sup>48</sup> Murphy, 'The Lunacy Commissioners and the East London Guardians', p. 521.

'harmless and demented' and the 'orderly and convalescent'.<sup>49</sup> The initial plans for these institutions were very much geared towards the latter group. In 1856 they were described as separate buildings within the asylum grounds, placed closer to the washrooms and the workshops than the rest of the dormitories, so that their residents could more easily go about their 'industrial pursuits'.<sup>50</sup> Their occupants were thus imagined to be physically healthy and easily managed, able to benefit from the new opportunities for self-control afforded to them by a domestic and industrious setting. Insofar as the aged were generally classed as 'harmless demented', or 'of the imbecile class', then we can assume that the Commissioners hoped that aged patients would also be transferred to these new institutions. However, the persistent image of a physically healthy, manually working population meant that the needs and abilities of the aged and infirm were not factored into the original plans. This was to prove problematic. When Caterham and Leavesden actually opened in 1870, it became clear that the 'harmless and demented [and physically feeble]' would dominate, rather than the 'orderly and convalescent [and healthy]'. With hindsight, in 1891, the superintendent of Caterham lamented the fact that the asylum had been built with a 'comparatively physically healthy population' in mind.<sup>51</sup> It was commonly stated in the early discussions of these intermediate asylums that 'for the chronic cases, of course, little attendance is required'.<sup>52</sup> Caterham and Leavesden decisively disproved this: in 1876 the Commissioners reported that, far from needing a reduced medical staff, both of the MAB asylums had hired an extra medical officer, due to the 'unremitting medical care' required by their patients.<sup>53</sup> As a writer in the *British Medical Journal* put it, 'These patients both require, and receive very careful treatment, and are necessarily costly to maintain'.<sup>54</sup> Thus, the experience of Caterham and Leavesden highlighted a problem in the Commissioners' thinking about the incurable residue: it consisted

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<sup>49</sup> *The Eleventh Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1857), p.23.

<sup>50</sup> *The Tenth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1856), pp. 26-27.

<sup>51</sup> *Minutes of the Metropolitan Asylums Board*, Vol. XXVI (1892-3), 12 November 1892, p. 582.

<sup>52</sup> *Report from the Select Committee on Lunatics; together with the proceedings of the committee, minutes of evidence, appendix, and index*, 1859 (156), VII.501, p. 120.

<sup>53</sup> *The Thirtieth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1876), p. 74.

<sup>54</sup> 'Caterham Asylum for Imbeciles', *British Medical Journal*, 2 (1886), p. 220.

of a class of patients that was significantly less promising than they had originally allowed themselves to believe.

The experience of Caterham and Leavesden appeared to dampen the Lunacy Commissioners' enthusiasm for intermediate asylums, and they ceased to promote them with such vigour. They came increasingly to view the workhouse as the correct site of care for aged and incurable demented. There was a long history of lunatics being housed in workhouses, which predated the 1834 Poor Law Amendment Act, and continued throughout the nineteenth century. As Peter Bartlett has pointed out, the 1834 Act made no explicit reference to asylums. There was, however, a reference to lunatics: clause 42 stated that no dangerous lunatic should be kept in the workhouse for more than 14 days.<sup>55</sup> Leonard Smith suggests that this was widely interpreted to mean that all lunatics should be sent to the asylum, which caused a noticeable upsurge in admissions.<sup>56</sup> In the 1840s and 50s, the Commissioners condemned the practice of retaining lunatics in workhouses. Their desire to see more lunatics transferred to the asylum was not confined to the 'dangerous'. According to Elaine Murphy, the Commissioners of this period 'assumed that it was merely a matter of time and sufficient expenditure before all mentally dependent people were transferred out of the control of the Guardians'.<sup>57</sup> In the 1860s, the situation changed. For Murphy, the key turning point was the passage of the 1862 Lunacy Act, which gave statutory legitimacy to the practice of removing incurable cases from the asylum to the workhouse. This was, she argues, 'the first breach of the Lunacy Commission's treasured principle that all insane patients should be removed from the control of the Poor Law authorities to the protection of the Justices and the Lunacy Act'.<sup>58</sup> From this point on, the Commissioners were far less likely to condemn the Guardians for not sending them lunatics, and more likely to criticise them for sending them the wrong type of lunatic, in increasing numbers.

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<sup>55</sup> Bartlett, *The Poor Law of Lunacy*, p. 44.

<sup>56</sup> Smith, *Cure, comfort and safe custody*, p. 7.

<sup>57</sup> Murphy, 'The Lunacy Commissioners and the East London Guardians', p. 512.

<sup>58</sup> *Ibid.*, p. 512.

In the 1870s, the cautious acceptance of the workhouse was replaced with a growing conviction that it was the *only* appropriate place (other than the family home) for the senile and other harmless incurables to be cared for. 'When conducted with liberality', wrote the Commissioners in 1873, '[workhouse lunatic wards] no doubt afford suitable accommodation for the class of chronic patients'.<sup>59</sup> As has already been discussed, the brouhaha over the four-shilling grant both reflected and reinforced the notion that the transfer of aged patients from the workhouse to the asylum was unacceptable. In 1880, the Commissioners advocated that the medical superintendents of Hanwell use 'every exertion' to remove cases of senile dementia under their care back to the workhouse, although they realised that the 'bodily weakness' of such patients may make such a transfer impossible.<sup>60</sup> This was a common complaint made by the MAB as we shall later see: once aged and worn-out patients had arrived at the asylum, they were impossible to remove, however much the asylum doctors objected, as the journey back to the workhouse was considered potentially fatal to those in a greatly aged or enfeebled state.

In the 1840s and 50s, the Lunacy Commissioners had been extremely critical of the standard of care offered on workhouse lunatic wards. As they looked increasingly to promote the workhouse as a site of care for certain types of lunatic, however, they began to paint these wards in a more positive light, publishing this glowing assessment of them in 1909:

It is impossible not to be struck with the happiness and contentment that prevails amongst the older inmates of these houses... It would be hard to find more suitable accommodation than is provided in many of the workhouses for certified patients of the inoffensive type.<sup>61</sup>

Thus, the care of aged and incurable lunatics in the workhouse ward had gone from being an unfortunate, but sometimes unavoidable evil, to a key strategy in the relief of the overcrowded asylum. By 1909, the Commissioners saw the workhouse as the

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<sup>59</sup> *The Twenty-Seventh Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1873), p. 18.

<sup>60</sup> *The Thirty-Seventh Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1883), p. 240.

<sup>61</sup> *The Sixty-Third Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1909), p. 68.

seat of the highest 'happiness and contentment' which could possibly be hoped for senile patients.

### **Senility at Hanwell**

The annual reports of Hanwell asylum show a similar trajectory, in terms of the attitudes expressed towards aged patients. In the mid-nineteenth century, these reports portrayed aged patients as sympathetic figures, and their presence was described as an inconvenient but largely benign fact of asylum life. In 1855 the matron, Catherine MacFie, produced particularly sentimentalised sketches of favoured, long-term patients who had aged and died under her care. When the so-called, 'Dowager countess', for example, died in 1855 aged 89, MacFie described her in reverent terms: '[Her] testimony was always accurate and honourable'; '[her] bible was her constant companion'; 'she was... a beautiful old woman'.<sup>62</sup> Such cases provided a testament to the tranquil, ordered domesticity of the asylum, and the success of the moral regime pursued there. Aged, long-term patients both held and embodied memories of the institution. In his final annual report as resident physician in 1844, John Conolly himself drew on the 'observable improvement' in the older patients as proof of the efficacy of non-restraint, despite 'the ineffable marks of bonds and iron and cord' on their bodies, which they still bore from the bad old days.<sup>63</sup> Between 1855 and 1875, Hanwell's resident population rose by almost 80 per cent (from 1,093 to 1,813). By the 1870s, no living testament to Hanwell's glory days remained, and any memories of them served as a reminder of how far the asylum had fallen from Conolly's utopian vision. Against this backdrop of rising patient numbers and mounting external criticism, the sentimentalised narratives of the aged disappeared. The administrators of Hanwell came to describe aged patients in the same terms as the Lunacy Commissioners; as problematic, unwanted, and inappropriate for asylum care.

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<sup>62</sup> *The Tenth Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1855), pp. 33-34.

<sup>63</sup> *The Seventy-Second Report of the Visiting Justices of the County Lunatic Asylum at Hanwell* (1844), p. 49.

In his 1874 report for the Lancet Commission on Lunatic Asylums, Joseph Mortimer Granville was dismissive of any pretensions Hanwell might have had to being a curative institution. 'It may be available as a place of refuge for imbecile and chronic cases of mental disease in which safe custody is the chief requirement', he wrote, 'but the notion of sending there acute or recent, and therefore potentially curable cases, should be wholly and at once abandoned'.<sup>64</sup> Joseph Peeke Richards, superintendent of the female department at Hanwell, agreed with Mortimer that their recovery rates mirrored the unfortunate character of the patients sent to him, but argued that this did not reflect the curative potential of the institution, or the medical skill of its staff. The *true* recovery rate, he suggested in 1878, could only be surmised if one ignored cases transferred from other institutions, and patients who were aged 60 or over on admission. Among the latter group the 'prospect of recovery [was] almost hopeless', and in any case, they were not truly insane but 'simply garrulous and restless from old age'.<sup>65</sup> This highlights one of the many tensions within the exclusionary discourse of senility: the aged were described as a group whose mental disturbance was so entrenched as to be almost irreversible, yet at the same time the seriousness of this disturbance was consistently downplayed as 'mere' or 'simple' restlessness.

Occasionally, the managers of Hanwell directly admonished individual Boards of Guardians for sending them cases they deemed to be unsuitable. In November 1869, Sarah Jarman, 'age said to be 80', was admitted to Hanwell from the workhouse of Westminster Union. On admission, she was reported as being 'very feeble and emaciated [and] not likely to live long'. In the opinion of James Murray Lindsey, Medical Superintendent of the female department of Hanwell, she 'ought not... to have been sent to the Asylum in her weakly and aged condition'. The Hanwell Visitors wrote to the Westminster Guardians to 'express [their] regret... that such a case should have been thought justifiable to expose the Patient to the trial of the journey'. Their comments, and the report from Murray Lindsey

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<sup>64</sup> J. Mortimer Granville, 'Report of The Lancet Commission of Lunatic Asylums', *The Lancet*, 107 (1876), p. 890.

<sup>65</sup> *The Thirty-Third Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1878), p. 25.

which they enclosed, focussed entirely on Jarman's physical condition, and made no reference to her mental state, other than to say that her 'restlessness and noise' had prevented them from conducting a thorough examination of her physical ailments. The Westminster Guardians responded with a report from J. G. French, the medical officer of their infirmary:

In the case of Sarah Jarman, - she was admitted into the Workhouse on no ground other than her insanity and the inability of her relatives to take proper care of her. In the Workhouse she was noisy and restless, perpetually moving about, and therefore requiring personal restraint. The Medical Officer deemed this to be the case which the law imperatively required to be removed to a Lunatic asylum, in order to protect the inmates of the Workhouse from annoyance.<sup>66</sup>

French replied to none of the Hanwell Visitors' concerns about Jarman's physical condition and focussed instead on her mental state and behaviour. Thus, while Lindsey and the Hanwell visitors viewed Jarman primarily as an old, infirm case, French and the Westminster Guardians saw her primarily as a lunatic. Sarah Jarman, and other people like her, was caught in between the classificatory schema used by different welfare institutions. Her physical state excluded her from the asylum (or from being seen as an appropriate asylum case), and her mental state excluded her from the workhouse. She was, in Foucault's terms, 'unclassifiable [and] inassimilable'.<sup>67</sup> Sarah Jarman's case suggests that the unclassifiable nature of the senile sharpened the very contours of what the administrators of lunacy imagined them to be. For both Drs French and Lindsey, the essential facts of Sarah Jarman's case corresponded to the ways in which she failed to adhere to the norms of their institutions.

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<sup>66</sup> *The Twenty-Third Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell*, (1868), pp. 17-23.

<sup>67</sup> Foucault and Lagrange, *Psychiatric Power*, p. 53.

## Senility and the Metropolitan Asylums Board

The Metropolitan Asylums Board (MAB) Imbecile Asylum at Caterham received a far greater proportion of aged admissions than Hanwell and other county asylums. This did not, however, mean that senile patients were more readily accepted there. The doctors and managers of Caterham complained about the admission of aged patients more often, in more detail, and with even greater levels of indignation than the Lunacy Commissioners. Their list of reasons to reject aged admissions was myriad and somewhat contradictory. On the one hand, they were said to take up an unwarranted amount of space on the wards, and yet, on the other, they supposedly often died soon after their arrival.<sup>68</sup> They were so 'easily managed' that there was no reason that they could not be cared for in the workhouse, yet they were also said to put too great a strain on the asylum, and necessitated the hire of more and more attendants to cope with the difficulty of caring for them.<sup>69</sup> They were acutely senescent, coming to the asylum only to 'linger longer or shorter time, and then die', yet were also 'perfectly sensible as to their surroundings... and often acutely fe[lt] the shock of their enforced removal, becoming depressed in spirits' and 'bitterly complain[ed] of what they consider an injustice in being sent to an Asylum to end their days'.<sup>70</sup>

The MAB's occasionally contradictory reasoning for excluding aged patients from their Imbecile Asylums belies a general distaste for the task of caring for infirm, demented patients. Ageing, dependent patients marred the vision they had for the asylum, and physically prevented them from running it the way they wanted. Rather than adjusting their expectations, the MAB continued to insist that these were the *wrong type* of patients for the new asylums - despite the fact that they were manifestly the type of patients for which such a new locus of care was needed.

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<sup>68</sup> *Minutes of the Metropolitan Asylums Board, Vol. X (1876-7)*, 2 December 1876, p. 534.

<sup>69</sup> *Minutes of the Metropolitan Asylums Board, Vol. XVI (1882-3)*, 15 April 1882, p. 46; *Caterham Sub-Committee Minutes (1900-1)*, p. 178; [Caterham] *Medical Superintendent's Report Book (1900-4)*, 16th February 1902.

<sup>70</sup> *Minutes of the Metropolitan Asylums Board, Vol. X (1876-7)*, 2 December 1876, p. 534; *Minutes of the Metropolitan Asylums Board, Vol. XX, (1886-7)*, 5 June 1886, p. 262; *Minutes of the Metropolitan Asylums Board, Vol. XXV, (1891-2)*, 20 Feb 1892, pp. 523-24.



As with the lunacy laws generally, there had never been a strict, official definition of what constituted a 'suitable' patient for the MAB asylums. Although they were championed by the President of the Poor Law Board, Gathorne Hardy, and remained under the authority of that body, the inspiration for the MAB asylums came from the Lunacy Commissioners, and their calls for an intermediate asylum. When first outlining his proposals to Parliament, Hardy quoted the 1859 report of the Commissioners at some length, declaring his intention to provide some alternative accommodation for chronic lunatics, 'instead of [their] being kept where they would only be in the way of inmates more needing special care'. As we have already seen, the Commissioners' idea of this group – quiet, docile and healthy – was quite inaccurate, as the opening of Caterham and Leavesden eventually showed. Although inspired by the Commissioners' plans, Hardy's aims were somewhat at odds with them. The Commissioners had hoped to relieve some pressure from their own county asylums, while Hardy's professed goal was 'to classify the different inmates of the workhouses'.<sup>71</sup> Indeed, the Metropolitan Poor Act, and the institutions built in its wake, was largely aimed at easing the overcrowding of the Metropolitan workhouses, and at rationalising the provision of Poor Law medical relief across the capital.<sup>72</sup> It was Hardy's vision which came to fruition: the opening of the MAB asylums saw workhouse lunatic wards across London empty, while Hanwell and other county asylums in the region felt little of the hoped-for relief.<sup>73</sup>

The details of the structure and purpose of the Imbecile Asylums was set out for the first time in an Order of the Poor Law Board in October 1875. It offered only this guidance as to who should be sent there:

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<sup>71</sup> *Hansard*, 1867, vol. clxxxv (third series) 8 February, cols. 161-74.

<sup>72</sup> Gwendoline M. Ayers, *England's First State Hospitals and the Metropolitan Asylums Board, 1867-1930* (London, 1971), pp. 4-6; Green, *Pauper Capital*, pp. 237-8.

<sup>73</sup> McCandless, "'Build! build!'" the Controversy Over the Care of the Chronically Insane in England, 1855-1870', p. 570.

The insane paupers to be received into this Asylum shall be such harmless persons of the chronic or imbecile class as could be lawfully retained in the Workhouse; but no dangerous or curable persons such as would, under the statutes in that behalf, require to be sent to a County Asylum, shall be admitted.<sup>74</sup>

This definition was more legally than practically oriented. It made it clear that there could be no cross-over between county and MAB asylums, and in doing so implicitly supported the *status quo*: anyone who might previously have been legally certifiable as a lunatic, and sent to a county asylum, should still be dealt with in the same way.

Despite having the word 'imbecile' in their names, Caterham and Leavesden Imbecile asylums shared little in common with the 'idiot asylums' and had never been intended to house the same class of patients as those provided for under the 1886 Idiot Act.<sup>75</sup> As the medical superintendent of Caterham admitted in 1900, 'the term "imbecile" asylum is a misnomer and somewhat misleading'.<sup>76</sup> Having said this, the use of that term points to the MAB's original hopes for these institutions: that they would be orderly places filled with healthy, obedient, industrious patient-inmates. Indeed in the early years, Caterham did function in this way, with one glowing article reporting that 'by far the greater part of the work' in maintaining the institution was performed by the patients.<sup>77</sup> Aged, feeble patients were an anathema to this industrious, hopeful vision: no wonder original and long-standing medical superintendent G. Stanley Elliot tried so hard to keep them out. But nothing in the founding documents of the asylum indicated that it should receive only healthy, trainable patients. Elliot and his assistants created the type of institution they wanted to work in, but not the one that was needed. He would look back on the early years of the asylum as a golden age, lamenting in 1891, 'I doubt that ever we shall see again a reversion to the class of case for which, in 1870, this

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<sup>74</sup> As quoted in Ayers, *England's First State Hospitals and the Metropolitan Asylums Board*, pp. 256-57.

<sup>75</sup> For more on Idiot Asylums, see Wright, *Mental Disability in Victorian England*.

<sup>76</sup> *Caterham Sub-Committee Minutes* (1899-1900), p. 268.

<sup>77</sup> William Gilbert, 'The Idiot Colony at Caterham', *Good Words*, 13 (1872), p. 274.

asylum was established'.<sup>78</sup> His memory of this time was perhaps not quite accurate: the proportion of admissions aged over 60 was as high in 1870-75 as in 1890-05. Yet this was not the narrative that persisted in the MAB's various reports. Rather than an institution which had misjudged its purpose, Caterham was presented as a place whose early promise had been thwarted by external agents.

Elliot and the other MAB administrators were thus faced with a patient body that was more difficult, costly and depressing to deal with than they had anticipated, and with a highly ambiguous set of admissions criteria which (they claimed) allowed the Guardians to send them anyone they wanted to get rid of. They responded to all of this confusion by trying to assert their own definition of a 'suitable' case, with almost exaggerated certainty. It seems that the very strength of the claim that senile cases had to care under the MAB, prompted them to dismiss this claim in equally strong terms. Thus, in the records of the MAB, the exclusionary discourse of senility is at its most heightened, as shown in this extract from Elliot's 1874 report (emphases his):

I would... again repeat the observations I made in my report of last year, with regard to the mental condition of many of the patients admitted, viz., those suffering from the ordinary effects of age... These are not *truly* insane, imbecile, or idiot, and ought *in no way* to be classed with them; they labour under no delusions, they give coherent answers, there is nothing irrational in their conduct; in many cases there is only "impairment" of mind or memory, which should not prevent their being treated in the ordinary hospital or workhouse infirmary.<sup>79</sup>

Unlike the managers of Hanwell, the MAB administrators could not object to aged patients being sent to them on grounds of incurability. Indeed, any patient suspected of being curable had by law to be immediately re-certified and sent to a

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<sup>78</sup> *Caterham Sub-Committee Minutes* (1897), 14th May 1897, p. 354.

<sup>79</sup> *Minutes of the Metropolitan Asylums Board, Vol. VIII* (1874-5), 5 December 1874, p. 359.

county asylum. The MAB therefore leaned particularly hard on the insistence that the senile were not '*truly*' insane. Almost every mention of aged admissions contained some objection that they were suffering 'merely from the helplessness and childishness incidental to advanced age', or 'only from the form of Dementia incidental to Senility'.<sup>80</sup> If such people were to be classed as insane or imbecile then, according to the Caterham annual report of 1873, 'every person who lives beyond his sixtieth or seventieth year... is liable to be so classed'.<sup>81</sup>

### *The MAB Response to the Problem of the Senile*

The MAB managers placed the blame for the unreasonable proportion of senile admittances firmly onto Poor Law Guardians and their officers, for lacking 'discretion' in deciding who to send to the imbecile asylums.<sup>82</sup> They were not afraid to cast aspersions on workhouse officers for having ulterior motives in removing these patients. In 1874 the Caterham Committee reported that 'The presumption is strong that many are removed to the asylum as the easiest means of getting rid of the trouble of nursing them'.<sup>83</sup> As far as the MAB were concerned, London's workhouses and infirmaries possessed sufficient resources for coping with senile dementia, and were the most appropriate place for such care to take place. London had a particularly well-developed network of workhouse infirmaries: by 1877, only six metropolitan unions lacked an infirmary building separate from their general workhouses.<sup>84</sup> However, the status of these institutions was also ambiguous. The *Lancet* commission on workhouse infirmaries was keen to emphasise that they should focus on treating the *acutely* sick, a group distinct from 'the aged and infirm'.<sup>85</sup> Thus, as in the case of the asylums, the aged were marginalised in the provision of medical care in London workhouses, because their ailments were not considered curable.

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<sup>80</sup> *Minutes of the Metropolitan Asylums Board, Vol. XVI (1882-3)*, 15 April 1882, p. 44; 13 May 1882, p. 173.

<sup>81</sup> *Minutes of the Metropolitan Asylums Board, Vol. VII (1873-4)*, 20 December 1873, p. 317.

<sup>82</sup> *Minutes of the Metropolitan Asylums Board, Vol. V (1871-2)*, 2 March 1872, p. 684.

<sup>83</sup> *Minutes of the Metropolitan Asylums Board, Vol. VIII (1874-5)*, 5 December 1874, p. 359.

<sup>84</sup> Green, *Pauper Capital*, p. 237.

<sup>85</sup> 'The Lancet Commission On Workhouse Infirmaries', *The Lancet*, 115 (1880), p. 187.

In an attempt to curb the tide of aged admissions to the asylum, the MAB managers regularly communicated their displeasure directly to the Guardians of those Unions and Parishes which had sent them particularly old and weak patients. This was often combined with an appeal to the Local Government Board (LGB) formally to condemn the Guardians' actions. On 9<sup>th</sup> December, 1878, a 75-year-old woman named Elizabeth Tunks was sent to Caterham from the Fulham Union workhouse. The Caterham Committee reported that she 'had bed sores, and was exceedingly debilitated'. She arrived at the asylum, they claimed, 'in such an exhausted state' that she died less than a week later. An inquest was held, and it was found that the strain of the journey from Fulham to Caterham had hastened Elizabeth Tunks' death, thus making the Fulham Guardians in part culpable for her demise. On hearing of this, the MAB managers resolved to send a copy of this report to both the LGB and to the Fulham Guardians. The LGB then entered into their own correspondence with the Fulham Guardians, inquiring into the facts of the case. They discovered that Tunks was removed several days after her certificate had been signed, during which time her physical condition had deteriorated significantly. The LGB's action in this case was simply to remind the Guardians to 'impress upon their officers' the importance of medically examining prospective asylum patients on the day of their removal.<sup>86</sup>

Occasionally, the MAB sought to elicit more comprehensive action from the LGB than just these piecemeal investigations. Throughout the first half of the 1870s, the MAB appealed for firmer regulations regarding appropriate cases for MAB imbecile asylum care.<sup>87</sup> These regulations did not materialise but in 1875, this rather limp paragraph was added to an unrelated circular letter sent from the LGB to the metropolitan unions:

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<sup>86</sup> *Minutes of the Metropolitan Asylums Board, Vol. XI (1877-8)*, 15th December 1877, pp. 639-40; 23 March 1878, p. 867; 12 January 1878, p. 698.

<sup>87</sup> *Minutes of the Metropolitan Asylums Board, Vol. VI (1872-3)*, 5th October, 1872, p. 326; *Minutes of the Metropolitan Asylums Board, Vol. VII (1873-4)*, 28th June, 1873, p. 115.

The removal of helpless bed-ridden persons, whose mental weakness is, in many cases, the result of old age, to Asylums situated a considerable distance from the Metropolis, is calculated, in the one hand to be injurious to the persons thus removed; and, on the other, to occupy the District Asylums with a different class of persons from that which they were constructed. It is obvious that such a course, if continued, could not fail to impose unnecessary expenditure on the Metropolitan Ratepayers.<sup>88</sup>

These comments, although they echoed the concerns of the MAB, barely amounted to a request, let alone a 'regulation', and had little effect. Faced with such equivocal support, the MAB tried to take matters into their own hands. In 1880, they sent their own circular letter to the metropolitan Guardians, 'calling their attention to the undesirability of sending to the Asylums of the Managers Patients who are simply suffering from Senile Decay'.<sup>89</sup> Then, in 1882, they took the further step of tabulating the number of cases of 'Dementia incidental to Senility' sent to their asylums from each Union. One of the managers moved to have this sent to the LGB, along with a further statement that their admission had caused 'an appreciable increase in the expenditure for maintenance and general management'. In the end, they voted not to send their findings to the LGB recalling, perhaps, the ineffectiveness of their appeals in the previous decade.<sup>90</sup>

There was a slight dip in the proportion of aged cases being sent to Catherham in the early 1880s, perhaps due to the actions of the MAB. However, by the 1890s, it had become clear that attempts to limit the number of aged cases arriving from the workhouses were having little long-term effect. The Board began to realise that they might have to come up with their own solution to manage the

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<sup>88</sup> *Correspondence from Government Bodies to Holborn Board of Guardians* (1875), p. 14.

<sup>89</sup> *Minutes of the Metropolitan Asylums Board, Vol. XIV* (1880-1), 29 May 1880, p. 240.

<sup>90</sup> *Minutes of the Metropolitan Asylums Board, Vol. XVI* (1882-3), 15 April 1882, p. 43; 13 May 1882, p. 173.

problem of the aged mentally ill. In 1892, a sub-committee of the MAB was set up to consider 'the whole question of imbecile accommodation'. They concluded

unanimously... that the time has now arrived when the Managers should no longer delay the provision of additional accommodation for imbeciles... [T]he accommodation needed is primarily for patients requiring infirmary treatment, your sub-committee consider that the establishment of an Asylum Infirmary in or within easy distance of the Metropolis for the reception of aged, helpless and enfeebled persons of unsound mind is expedient and desirable.<sup>91</sup>

They quoted from G. Stanley Elliot's report of the previous year, where he had been the first to suggest that an 'asylum infirmary' was needed, to care for 'the very aged helpless, and enfeebled persons of unsound mind' who clearly made up a significant proportion of London's indigent poor.<sup>92</sup> This, at last, was a recognition that the needs of the aged mentally ill, and other people whose physical needs were equal to their mental ones, were not currently being catered for in London, and that some new structure of care was needed. Elliot produced a full proposal for the MAB the following year, which attempted to do away with the old notion that this care could be cheaply provided, and noted that the patient population would consist chiefly of 'persons requiring exceptional individual attention'. The proposal was quickly accepted by both the MAB and the LGB, and in May 1894, the Tooting Lodge estate was purchased.<sup>93</sup>

It would, however, be almost ten years before the Tooting Bec Asylum received its first patient, largely due to the hesitance of the Local Government Board. They did not heed Elliot's warning that such care could only be provided at considerable expense. Before they would sanction the purchase of Tooting Lodge,

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<sup>91</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXVI (1892-3)*, 12 November 1892, p. 582.

<sup>92</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXVI (1892-3)*, 14 May 1892, p. 114; 12 November 1892, p. 582.

<sup>93</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXVIII (1894-5)*, 26th May 1894, p. 150.

they asked repeatedly for reassurance about the 'class of patients' it would be intended to accommodate. They insisted that all of the patients at the new asylum be certified under the Lunacy Act. This was less an attempt to protect the patients from unlawful detention, than an act of deterrence against 'cases of ordinary senile decay'.<sup>94</sup> The opening of Tooting Bec, then, can be seen as a missed opportunity to circumvent the dysfunctional exclusionary discourse of senility. By insisting that its residents be certifiable lunatics, rather than 'cases of ordinary senile decay', the LGB ensured that Tooting Bec would be hampered by the classificatory problems which had surrounded aged asylum admissions for decades. It also highlights the continued unwillingness, at the highest levels of the administrative structures at least, to accept responsibility for caring for this group of patients, even in an institution which was explicitly set up to cater for their needs. The LGB, more isolated from the problems with which the MAB had been dealing over the preceding thirty years, were also more conservative in their estimates of the scale of the problem. Over the next decade, they wrangled over bed numbers, convinced that the numbers proposed by the MAB exceeded the number of prospective patients whose problems were 'within the terms of Dr Elliot's definition'.<sup>95</sup> This was soon shown to be a grave error on the LGB's part, and in 1906, only three years after opening, the asylums committee had to appeal to the LGB for permission to install an additional 207 beds.<sup>96</sup>

In the years leading up to the opening of Tooting Bec, the MAB seemed content to believe that it would solve many of their problems. In 1902, they made arrangements for the transfer of 200 healthy, younger patients from Darenth to Caterham and Leavesden, in anticipation of the space which would be vacated by patients moved out to Tooting Bec.<sup>97</sup> The original intention had been to house all of the MAB's aged patients at the new asylum. Only a year after opening, under the weight of new admissions, this policy had to be abandoned, and a group of patients

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<sup>94</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXVII (1893-4)*, 6 January 1894, p. 636.

<sup>95</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXIX (1895-6)*, 11 May 1895, pp. 115-16.

<sup>96</sup> *Minutes of the Metropolitan Asylums Board, Vol. XLI (1907)*, 12 October 1907, p. 202.

<sup>97</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXXVI (1902)*, 4 October 1902, p. 596.



aged between 70 and 80 were transferred back to the other imbecile asylums.<sup>98</sup> In the same year, Dr Campbell, superintendent of Caterham, submitted a proposal to convert two more existing wards into infirmary accommodation.<sup>99</sup> Once again, the experience of the county asylums was being repeated, as the creation of a new institution seemed to increase demand rather than negate it. It seems that all involved had seriously underestimated the extent of the need for asylum infirmary accommodation in London. Caterham did not experience the expected relief and, in his annual report for 1905, Campbell stated that 'in no previous year...have the admissions been as unsatisfactory as in the last twelve months'.<sup>100</sup> Tooting Bec was originally designed as the first real example of the cheap, simple accommodation for the senile, which had for so long been touted as the answer to the problem of the aged in the asylum. In reality, Tooting Bec proved that the notion that the senile could be cared for cheaply was a fallacy. When Arthur Downes, senior medical inspector for the LGB, appeared before the Royal Commission for the Care and Control of the Feeble Minded, he was pressed on the question of whether senile demented could be so accommodated. 'I am not sure that the senile demented who are sent to Tooting Bec could be dealt with cheaply,' he said, 'because they are cases which require enormous care in nursing'.<sup>101</sup> The dream of the cheap institution would not die, however: Downes described Tooting Bec, originally designed to be as economical as possible, as 'of course, of a more expensive type', while Mr Helby, Chairman of the MAB, wondered whether some of Tooting's patients might be cared for in an infirmary ward at the workhouse. 'The cost would be less', he stated.<sup>102</sup>

Thus, the opening of Tooting Bec asylum did not actually mark a change in attitude on the part of the MAB, nor did it provoke any new insights on the nature

<sup>98</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXXVIII (1904)*, 15 October 1904, p. 507.

<sup>99</sup> *Medical Superintendent's Report Book (1900-4)*, 12th February 1904.

<sup>100</sup> As quoted in *Report of the Royal Commission on the Care and Control of the Feeble-Minded. Volume VIII.*, (Cd. 4202, 1908), pp. 66-67.

<sup>101</sup> *Minutes of Evidence (Relating to England and Wales on the Original Reference). Taken Before the Royal Commission on the Care and Control of the Feeble-Minded with Appendices and Witnesses Index*, (Cd. 4215, 1908), pp. 97, 103.

<sup>102</sup> *Minutes of Evidence...Taken Before the Royal Commission on the Care and Control of the Feeble-Minded*, pp. 97 *Report of the Royal Commission on the Care and Control of the Feeble-Minded. Volume VIII*, p. 67.

of the problem from amongst the managers. Helby repeated the same old arguments as had been made following the opening of Caterham and Leaveden, blaming the unexpected expense of Tooting Bec on the admission of the wrong type of patient: 'nothing more nor less than old men or women suffering from senile decay'.<sup>103</sup> The exclusionary discourse of senility was so embedded at the MAB, that it was even being applied to an institution set up explicitly to care for senile demented. The managers continued to hold on to the idea of a fathomable, objective, and well-understood boundary between senile dementia and natural infirmity, when experience clearly pointed to the difficulties of making this distinction meaningful in the practical question of institutional care. Following the opening of Tooting Bec, the MAB managers returned to their previous strategy of seeking out the Unions who sent them aged patients so that they could be admonished. In 1904, they sent out a return to all metropolitan Guardians, asking how many people over 70 they had sent to the MAB asylums, and – in a more direct insinuation of illegitimate activity than they had ever previously made – how much they had paid the physician who certified them.<sup>104</sup> In the end very little came of it: certain Guardians replied only to add their own condemnation to the practice and trumpet their own innocence, and no one admitted to the dubious practice of paying for medical certificates.<sup>105</sup> This episode does, however, show us that the MAB managers continued to see the problem of aged admissions in the same terms; as one caused by unscrupulous poor-law officials who knowingly sent them unequivocally unsuitable cases, to save themselves some trouble.

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<sup>103</sup> *Report of the Royal Commission on the Care and Control of the Feeble-Minded. Volume VIII*, p. 67.

<sup>104</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXXIX* (1905), 18 February 1905, pp. 44-5; 15 April 1905, p. 99.

<sup>105</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXXIX* (1905), 27 May 1905, p. 137; 24 June 1905, p. 155; 8th July 1905, p. 167.

### The View from the Workhouse

The proportion of admissions to Caterham who were aged 60 or over did not steadily increase during this period, but neither did they decrease.<sup>106</sup> By continuing to arrange for aged patients to be admitted to the MAB asylums, workhouse officials and Poor Law Guardians showed that they considered senile cases to be appropriate for MAB asylum care. Individual Boards of Guardians pushed back against the MAB when they sent them letters of complaint about aged patients, writing their own letters to defend their decisions.<sup>107</sup> In April 1897, the Guardians of Poplar Union turned the tables on the MAB, criticising *them* for the insufficiency of provision at their imbecile asylums. 'The want of accommodation', they reported, was leading to many difficult patients being detained in the workhouse, an 'extremely undesirable' situation. In light of this, they requested that the MAB provide temporary accommodation for those imbeciles who were currently awaiting transfer to one of their asylums.<sup>108</sup> The MAB took almost a year to respond to this highly unusual missive. They undertook their own survey of the number of imbeciles currently awaiting transfer to a MAB asylum in metropolitan workhouses. Excluding those 'requiring infirmary accommodation', who, they claimed, would soon be provided for by Tooting Bec Asylum, and anyone else under 16 or over 70, they declared there to be only 46 such people awaiting accommodation. Thus they were 'not prepared to incur any expenditure on the provision of temporary

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<sup>106</sup> Between 1871-75, 28 per cent of new admissions to Caterham were aged 60 or over. This fell to 21 per cent in 1881-85, perhaps due to complaints of the Managers, but rose again to 30 per cent in 1891-95. The proportion only fell decisively, to 14 per cent, in 1906-10, following the opening of Tooting Bec.

<sup>107</sup> For example, in 1890, the Guardians of Bethnal Green Poor Law Union defended their medical officer's assertion that an 86-year-old woman, who had died days after her arrival at Caterham, was 'quite in a fit state to be removed'. In 1892, when the MAB managers complained about the arrival two patients aged 84 and 76, who had been sent from the Parish Street Workhouse in the St Olave's Union, the St Olave's Guardians dismissively refused to accept any blame, arguing that it was the Justices who were responsible for the certification of the senile, a matter into which the Guardians were 'unable to interfere'. *Minutes of the Metropolitan Asylums Board, Vol. XXIII* (1889-90), 8 March 1890, p. 755; *Minutes of the Metropolitan Asylums Board, Vol. XXV* (1891-2), 23 January 1892, p. 729; 20 Feb 1892, pp. 523-4; *St. Olave's Union: Minutes* (1881-2) 21 Jan 1892, p. 569; 17th March 1892, p. 757; *Minutes of the Metropolitan Asylums Board, Vol. XXVI* (1892-3), 30 April 1892, pp. 42-3.

<sup>108</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXVI* (1892-3), 30 April 1892, p. 44.

accommodation for this class of patient'.<sup>109</sup> It is hardly surprising that the results of the MAB's investigation supported the *status quo*. Indeed, by excluding the over-70s and the feeble from their enumeration – potentially discounting many of the patients to whom the Poplar Guardians originally referred – the MAB indicated from the outset that they would not adjust their own activities and expectations to meet the needs of the Guardians. They were only prepared to tackle the question of imbecile accommodation on their own terms. This episode thus underlines how differently the MAB and the Guardians viewed the problem of imbecile accommodation. The unions thought that gaining entry for one of their paupers into the imbecile asylums was far too difficult; as far as the MAB was concerned, Guardians sought their services far too readily.

At the turn of the century, the opening of Tooting Bec asylum, and the investigations undertaken by two Royal Commissions - on the Poor Laws, and on the Care and Control of the Feeble Minded - brought fresh attention to the issue of accommodation for the senile. In 1905, Dr F. S. Toogood, long-standing medical superintendent of the Lewisham workhouse infirmary, spoke out at a meeting of the MPA, expressing his concerns about 'the growing unwillingness of the London County Council and the Metropolitan Asylums Board to receive cases of senile dementia into their asylums'. He directed particular criticism to Dr P. Campbell, medical superintendent of Caterham.

[A] tremendous fuss had been made by the Metropolitan Asylums Board, on the complaint of the medical officer at Caterham Asylum, against the sending of those senile demented down there. That gentleman appeared to forget that Caterham Asylum was established for dealing with those cases. It was a workhouse designed for that class of case.<sup>110</sup>

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<sup>109</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXXI (1897-8)*, 12 March 1898, p. 951.

<sup>110</sup> John Milsom Rhodes, 'The Provision of Suitable Accommodation for the Various Forms of Insanity', *Journal of Mental Science*, 51 (1905), pp. 681-710.

A year later, Toogood wrote in the *Lancet* that there had been 'a growing feeling that cases of senile dementia should not be classed as lunatic', but countered that they were equally undesired as infirmary patients:

Old people who cannot find their way about a ward, who are unable to recognise their own beds, who prowl about the place in a semi-nude condition, who try to get into bed with other inmates and who resent their exclusion, who sing and chatter and call upon imaginary persons all night, who would, if not prevented, light fires upon the floor, are not sufficiently docile to be retained in ordinary workhouse dormitories, while their presence in an infirmary ward would be intolerable.<sup>111</sup>

This hardly accords with the image of the 'quiet and harmless' patients described by the MAB and the Lunacy Commissioners. Workhouse officials, thus, had their own exclusionary discourse of senility, one which portrayed their behaviour as so difficult, that it was impossible for them to remain on a general infirmary ward. Out of 276 Boards of Guardians asked by the Royal Commission on the Poor Laws and the Relief of Distress, only *one* (rural) Board agreed that 'senile dementals should not be treated in lunatic asylums, but should be treated in workhouses'.<sup>112</sup>

In 1908, C.T. Parsons, Honorary Secretary of the Infirmary Medical Superintendents' Society, and medical officer of the Fulham Infirmary, wrote letters to both the *British Medical Journal* and *The Lancet*, putting forward his perspective on 'The Difficulty of Dealing with Cases of Senile Insanity'.<sup>113</sup> His use of the term 'senile insanity' was as strategic and loaded as the use of 'mere senile dementia' by the Lunacy Commissioners and the MAB. His argument focussed on the 'grave

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<sup>111</sup>F. S. Toogood, 'Ten years of Lunacy Treatment in Lewisham Infirmary', *The Lancet*, 168 (1906), p. 705.

<sup>112</sup>*Royal Commission on the Poor Laws and Relief of Distress. Appendix volume XI. Miscellaneous*, (Cd. 5072, 1910), p. 146.

<sup>113</sup>C. T. Parsons, 'The Difficulty of Dealing with Cases of Senile Insanity: Where are they to be Accommodated?', *The Lancet*, 172 (1908), pp. 1706-7; C. T. Parsons, 'Senile Dementals In London', *The British Medical Journal*, 2 (1908), pp. 1720-21.

accusation' implicit in the complaints about senile admissions to the asylum: 'that not only are patients being sent to these asylums illegally, but that they are also being detained illegally'. The law was quite clear, he knowingly suggested: if an individual was not a fit case for the asylum, then they could not legally be certified. The unspoken corollary, of course, was that any person who was being detained under a certificate of lunacy *must*, therefore, be insane.<sup>114</sup> Like the administrators of lunacy, then, C. T. Parsons and other Poor Law officials manipulated the uncertainty around what constituted insanity to their own ends. Both asylum and workhouse officials appealed to an objective and externally-verifiable definition of a 'true' lunatic in their arguments about the senile, but their experience showed that the only meaningful definition of insanity in this context was a practical one, dictated by the type of behaviour different institutions were prepared to tolerate, and type of the care they were willing to provide.

## Conclusion

Historian David Mellett has described the history of lunacy reform as 'the history of the idealization of an expedient'.<sup>115</sup> This chapter has shown that, with regards to the issue of senile lunatics, the precise opposite was the case. The continued arrival of aged patients at the asylum, apparently in ever-increasing numbers, demonstrates that the admission of such patients to the asylum was indeed 'expedient' to someone. This situation, however, was in no way idealised: the Lunacy Commissioners, asylum managers, and many psychiatrists continually and vociferously complained about their institutions being used in this manner. Rather than accept a role which they were being called upon to perform, and adjust their understanding of the asylum accordingly, the administrators of lunacy coveted an imagined alternative. In doing so, they attempted to exclude the senile from the legitimate asylum population, rhetorically and literally. In practical terms, as the restricted size of Tooting Bec Asylum demonstrates, this alternative was never sincerely pursued. The expedient triumphed over the ideal.

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<sup>114</sup> Parsons, 'Senile Dements In London', p. 1720.

<sup>115</sup> D. J. Mellett, *The Prerogative of Asylums: Social, Cultural, and Administrative Aspects of the Institutional Treatment of the Insane in Nineteenth-Century Britain* (New York, 1982), p. 159.

The admission of aged patients to the asylum was not, by their own admission, expedient to those who controlled and organised the institutional care of insanity. This begs the question: for whom was this situation expedient? This is the question which will be addressed in the next chapter. It will show that, far from being an aberration, the admission of aged patients to the asylum was entirely consistent with the role that institution performed within nineteenth-century English society. Asylum admission was essentially a pressure-valve for families and workhouses when an individual's behaviour became unmanageably disruptive. In this context, any attempt to differentiate between 'senility' and 'insanity' was meaningless.

### Chapter Three: Older Patients' Journeys to Hanwell

Sarah Townsend was employed for 30 years in the family of a wealthy tea merchant, in Hampstead, North London. Her primary role was as a nurse to the family's nine children. In 1891, the youngest child turned 12, and Sarah turned 60. Sarah began to worry about her position. According to her family, she grew melancholy and lethargic, fearing that her employers 'did not want so old a servant'. Matters came to a head when she reportedly 'took a razor to bed with her intending to cut her throat'. Sarah had never married, and had no children of her own, but her sisters stepped in to look after her. First, she was taken in by her sister and brother-in-law, who lived locally. After a few days, they decided to send her to stay with another sister, named Martha, in Southport, Lancashire, hoping that the 'rest and change' would improve her state of mind. For four weeks Martha made sure that Sarah ate and dressed, and generally found her to be 'tractable', but in the fifth week Sarah's behaviour deteriorated. She became very restless, attempting to leave the house without any clothes, and reacting violently when prevented. At this point, Martha later explained, her sister became 'unmanageable'. Martha's son solicited a certificate of insanity for Sarah, and she was admitted to Lancaster Lunatic Asylum. When the 'authorities' there discovered that Sarah was a Londoner, chargeable to the Hampstead Poor Law Union, they transferred her back down to the metropolis. Sarah entered Hanwell on 5th February 1892.<sup>1</sup>

Rebecca Tully was a widowed needlewoman, aged 82, when she was admitted to Hanwell in 1872. No one came to the asylum to tell the story of her case, and there are no letters attached to her case note. The asylum had the name and address of her grandson, but when the Clerk tried to reach him, his letter was returned, with a note saying that he was 'not known'. The only description of Rebecca's life prior to her admission comes from her medical certificate. She was living alone, in a single room in a lodging-house. The certifying doctor wrote that he 'found her at her lodging...in a most disgusting state, her hands covered with her own excrement and the room in a most filthy state.' Her landlady added that

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<sup>1</sup> Sarah Townsend, Hanwell Casebook, Females No. 14, H11/HLL/B/19/037 (1892), p. 271.



‘she had not been off her bed for the last month, that she had laid in her own excrement, that she had several times nearly set fire to her own room’. The landlady, it seems, had not seen fit to intervene, beyond soliciting Rebecca’s certification and seeing her sent to the asylum.<sup>2</sup>

Sarah and Rebecca were both categorised as ‘senile’ by the medical officers at Hanwell, but in neither case does their route to the asylum conform to the stereotype described in Chapter Two. There, we saw that the Lunacy Commissioners cast aspersions on the motives of families, as well as Poor Law officials, for illegitimately sending them senile cases. They accused ‘poorer’ families of sending their ‘worn out’ members to the asylum ‘without reluctance’.<sup>3</sup> Sarah Townsend’s family, in fact, seemed very reluctant to send her to the asylum, even after she showed an intent to commit suicide. They went to significant lengths to manage Sarah’s condition amongst themselves although, in the end, her problems proved ‘unmanageable’. Rebecca Tully, in contrast, was living in abject neglect, alone and in clear need of care and support.

This chapter will examine critically the journeys which led aged patients to Hanwell, and tease out some of the experiential consequences of being old, mad and poor. The question of how and why people entered the asylum has been a matter of much historiographic discussion and debate, as has the position of the aged with regard to the family, the community and welfare institutions. This chapter will therefore begin with an extended, two-part discussion of these areas of historiography. It will then move on to analyse evidence from the medical certificates and case-history narratives of patients who were aged 60 or over when they were admitted to Hanwell. The medical certificate was the document which legally gave patients the status of a ‘lunatic’, and allowed them to be confined against their will. The certifying physician – who was not usually affiliated with the asylum – had to provide ‘facts indicating insanity’, which he had observed himself,

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<sup>2</sup> Rebecca Tully, Hanwell Casebook, Females No. 23, H11/HLL/B/19/023 (1872), p. 61.

<sup>3</sup> *The Forty-Eighth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1894), p. 6.

and which had been 'communicated by others'.<sup>4</sup> From the 1870s, these documents were copied into the case notes at Hanwell, and often indicate the sequence of events leading up to a patient's institutionalisation. The case history narratives were the product of interviews conducted with a patient's friends or family members by the asylum doctors themselves, shortly after the patient's admission.<sup>5</sup> They included details of the patients' experiences, habits and mental condition. Although they were not recorded verbatim, these narratives offer a rich insight into the lay understanding of mental disorder. They, like the certificates, also contain details regarding patients' domestic situations, and the circumstances and events leading up to their institutionalisation. Together, the certificates and case history narratives sometimes allow us to piece together a picture of patients' journeys to the asylum.

In examining journeys to the asylum, this chapter seeks to illuminate two main themes: personal responses and institutional displacements. To explore the personal, it will first examine the lives of the patients in this sample immediately prior to their admittance to Hanwell, focussing on the relationships they had with people around them, and the dynamics of obligation and affection which underscored these relationships. It will suggest that there was a general sense of social obligation amongst adult children, extended family members, and friends, to provide support for older people who became mentally disordered. It will also show that this social ideal was often unfulfilled – due to practical constraints or simply a lack of desire and interest – and older people regularly fell on charitable organisations and on the Poor Law for support.

This chapter will suggest that admittance to Hanwell was usually the last step in a chain of institutional displacements: from the home to the workhouse, and from the workhouse to the asylum. There were also sometimes other displacements in this chain, from independent dwellings to relatives' homes – as in Sarah

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<sup>4</sup> The 'facts indicating insanity' were not included in pauper lunatic certificates until after the 1853 Asylums Act. For more detail on the process of certification, see David Wright, 'The Certification of Insanity in Nineteenth-Century England and Wales', *History of Psychiatry*, 9 (1998), pp. 274-282.

<sup>5</sup> For further discussion of the form and purpose of the case history narrative, see pp. 220-224.

Townsend's case – or to charitable institutions. Viewed in this light, the act of admitting a person to the asylum can be seen on a continuum with other attempts to manage or contain the behaviour of disruptive individuals. Institutional displacement occurred when a person's behaviour overwhelmed the resources – financial, practical and emotional – available to manage and support them.

Trying to determine why people were sent to the asylum, even in a small-scale study, is a highly loaded endeavour. As historians Joseph Melling and Robert Turner have pointed out, 'we can see the decision to dispatch a family or community member as a product of the same complex of forces which gave birth to the institution itself.'<sup>6</sup> In trying to determine why individuals ended up within the asylum walls, the entire meaning of the institution is at stake. This chapter fully embraces this broader implication. It builds on the argument from the previous chapter that attempts to exclude 'senile' patients from the asylum – discursively or practically – were futile. In practical terms, the asylum functioned as a place to contain a wide variety of disruptive or unmanageable behaviours, including those which may have arisen from the 'natural infirmity of old age'.

### **The Historiography of Asylum Admission**

In the 'post-revisionist' historiography of the asylum, described in the introduction to this thesis, the role of the family in admitting patients to the asylum came to the fore. David Wright's 1997 article 'Getting Out of the Asylum' is the definitive statement of this programme of research. Wright suggested that historians move beyond the history of 'psychiatry' – with a focus on medical practices and power within the institution – to a history of 'confinement'.<sup>7</sup> This approach, he stated, would highlight the pre-eminence of non-medical actors in the process of committal to the asylum, and debunk attempts to paint the growth of the asylum as a straightforward product of medical imperialism. Asylum doctors had very little

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<sup>6</sup> Joseph Melling and Robert Turner, 'The Road to the Asylum: Institutions, Distance and the Administration of Pauper Lunacy in Devon, 1845-1914', *Journal of Historical Geography*, 25 (1999), p. 300.

<sup>7</sup> David Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine*, 10 (1997) p. 139.

control over asylum admissions, as was made very clear in the complaints discussed in Chapter Two. The physicians who completed and signed the medical certificates did not come from within the asylum: they were private physicians, or workhouse medical officers, and rarely had a specialist interest in psychiatry.<sup>8</sup> Poor Law officials also often played an important role in instigating and organising the process of certification and removal.<sup>9</sup> Elaine Murphy has suggested that the workhouse medical officer was the key actor in the decision to seek committal for paupers in the Poor Law unions of East London.<sup>10</sup> The role of Poor Law officials and workhouse employees will thus be given significant consideration in this chapter. It is the family, however, which has received the most attention in the historiography of asylum admissions. Akihito Suzuki has described the family as the 'real agent' in the certification process: most often, he suggests, a family member made the initial approach to the authorities to set this in motion, and their testimony was often key to the establishment of a relative's insanity. Thus, it was the family, not the medical authorities, who turned a sick person into a 'patient'.<sup>11</sup>

In highlighting the role of the family, post-revisionist historians have been particularly eager to represent families as agents: as people exercising choice over how to deal with their difficult relatives. This is a response to the perceived structuralist tendencies of revisionist approaches. As Melling, Forsythe and Adair put it, more recent historiography has

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<sup>8</sup> Joseph Melling, Richard Adair and Bill Forsythe, "'A Proper Lunatic for Two Years': Pauper Lunatic Children in Victorian and Edwardian England. Child Admissions to the Devon County Asylum, 1845-1914', *Journal of Social History*, 31 (1997), p. 378.

<sup>9</sup> Peter Bartlett, *The Poor Law of Lunacy: the Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London, 1999), pp. 153-55.

<sup>10</sup> Elaine Murphy, 'The Lunacy Commissioners and the East London Guardians, 1845-1867', *Medical History*, 46 (2002), p. 513.

<sup>11</sup> Akihito Suzuki, *Madness at Home: the Psychiatrist, the Patient, and the Family in England, 1820-1860* (Berkeley, 2006) p. 1.

consistently challenged Foucaultian interpretations of the asylum as an instrument of social control and have stressed the capacity and willingness of working class families to make effective use of such facilities.<sup>12</sup>

The 'capacity' of families to deal with difficult members has been analysed through what Melling Forsythe and Adair call the 'domestic economy of welfare', which echoes the 'household economies' approach popular in the social history of the family.<sup>13</sup> Historians working in this mode use asylum and Poor Law records to uncover the material hardships and practical limitations which preceded instances of institutionalisation. The life course, migration patterns, family size, and the pauperising effects of mental disruption have all been named as factors affecting the distribution of resources within the family, and their ability to cope with dependent or unproductive members.<sup>14</sup> This approach, then, aims to reconstruct the immediate economic and social context from which asylum patients originated. At the same time, historians of the family have long been well aware that household structure only tells us so much about the people it represents. As David Morgan put it, 'sociologically...two households might not, in any sensible way, be the same, even if they are demographically very similar.'<sup>15</sup> This is one of the strengths of asylum records; they add an indispensable further layer of qualitative information to allow us to make more informed insights – if not firm conclusions – about the nature of the family relationships behind the demographic data.<sup>16</sup> The 'capacity' of families to provide care to old and insane relatives depended on more than just

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<sup>12</sup> Joseph Melling, Bill Forsythe and Richard Adair, 'Families, Communities and the Legal Regulation of Lunacy in Victorian England: Assessments of Crime, Violence and Welfare in Admissions to the Devon Asylum, 1845-1914', in Peter Bartlett and David Wright (eds), *Outside the Walls of the Asylum: the History of Care in the Community 1750-2000* (London, 1999), p. 153; Michael Anderson, *Approaches to the History of the Western Family, 1500-1914* (London, 1980) pp. 49-67.

<sup>13</sup> Melling, Forsythe and Adair, 'Families, Communities and the Legal Regulation of Lunacy in Victorian England', p. 153.

<sup>14</sup> Melling, Forsythe and Adair, 'Families, Communities and the Legal Regulation of Lunacy in Victorian England', pp. 154, 172; David Wright, *Mental Disability in Victorian England: the Earlswood Asylum, 1847-1901* (Oxford, 2001) p. 83.

<sup>15</sup> D. H. J. Morgan, *The Family, Politics, and Social Theory* (London, 1985), p. 162; See also Hans Medick, 'The Proto-Industrial Family Economy: The Structural Function of Household and Family during the Transition from Peasant Society to Industrial Capitalism', *Social History*, 1 (1976), p. 295

<sup>16</sup> This was recognised by Wright, 'Getting out of the Asylum', p. 152.

their economic position and demographic structure: illness, personal history and personality all impacted on the ability of a family to meet the needs of a dependent elder.

This brings us to the second element of Melling et al.'s statement, quoted above: the 'willingness' of families to provide care. A focus on 'willingness' has kept the agency of families at the heart of the history of the asylum. By including feelings and moral values among the factors which influence domestic decision-making, post-revisionist historians have avoided painting working-class families as automata reacting in an instrumental manner to structural economic forces.<sup>17</sup> Thus, while the humanitarianism of the medical profession has become a historiographic taboo, the humanitarianism of the family holds a place at the centre of post-revisionist asylum historiography. John Walton, one of the earliest proponents of this approach, insisted that 'the requirements of [a] theoretical structure should not be allowed to disguise the persisting importance of what people thought was right'.<sup>18</sup> Andrew Scull's work, described in the Introduction to this thesis, has been used as the primary example of a history which serves a 'theoretical structure' to the detriment of the values and emotions of the people involved. In particular, his description of the asylum as 'a convenient place to get rid of inconvenient people' has attracted attention, and criticism, from other historians. This was the title of a chapter written by Scull and included in a volume on 'the social development of the built environment' from 1980.<sup>19</sup> It does not appear in his major monograph on the Victorian asylum, *Museums of Madness*, nor in the revised version of that work. It remains, however, one of his most oft-quoted statements.<sup>20</sup> Walton invoked it

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<sup>17</sup> Melling, Forsythe and Adair, 'Families, Communities and the Legal Regulation of Lunacy in Victorian England', p. 153.

<sup>18</sup> John K. Walton, 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848-50', *Journal of Social History*, 13 (1979), p. 17.

<sup>19</sup> Andrew Scull, 'A Convenient Place to Get Rid of Inconvenient People: the Victorian Lunatic Asylum', in Anthony D. King (ed.), *Buildings and Society: Essays on the Social Development of the Built Environment* (London, 1980), pp. 37-60.

<sup>20</sup> A sample of these includes Sarah Wise, *Inconvenient People: Lunacy, Liberty and the Mad-Doctors in Victorian England* (London, 2012); Jonathan Andrews, 'The Rise of the Asylum in Britain' in Deborah Brunton (ed.), *Medicine Transformed: Health, Disease and Society in Europe 1800-1930* (Manchester, 2004), p. 309; Edgar-André Montigny, "'Foisted Upon the Government": Institutions and the Impact of Public Policy Upon the Aged. The Elderly Patients of Rockwood Asylum, 1866-1906', *Journal of Social History*, 28 (1995), p. 819; Roy Porter and David Wright (eds), *The Confinement of*

directly, arguing that asylum admittees 'were not so much "inconvenient" people, in Scull's terminology, as impossible people in the eyes of families, neighbours and authorities'.<sup>21</sup>

Following Walton's example, a strain of asylum history has emerged which seeks to emphasise that families did not institutionalise their relatives because they did not care about them, but because they did. The only historical article to address the admission of aged asylum patients specifically is very much in this vein.<sup>22</sup> In his study of aged admissions to the Rockwood Asylum in Ontario, Canada, Edgar-André Montigny asserted that his aim was

to determine if families...acted in the way Andrew Scull suggested and abandoned their burdensome aged relatives to insane asylums to be rid of them, or if they committed elderly people to institutions only as a last desperate resort in the absence of viable alternatives.<sup>23</sup>

Such analyses have provided an important corrective to the idea, made explicit by David Mellett, that the asylum constituted a 'first resort' solution to a variety of social problems.<sup>24</sup> They emphasise the long gap between the appearance of symptoms and institutionalisation, and demonstrate that families might be suffering significant hardship when the decision to institutionalise was finally made. Historians like Walton and Montigny thus usefully moderate Scull and Mellett's polemic tone. However, when historians of the asylum continue to frame their analyses in this way – arguing that people were admitted to the asylum because they were 'impossible' rather than 'inconvenient' – they risk overplaying

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*the Insane: International Perspectives, 1800-1965* (Cambridge, 2011), p. 4; J. L. Crammer, 'English Asylums and English doctors: Where Scull is Wrong', *History of Psychiatry*, 5 (1994), p. 103.

<sup>21</sup> John K. Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-70', in William F. Bynum, Roy Porter and Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume II: Institutions and Society* (London, 1985), p. 141.

<sup>22</sup> Yorston and Haw do not discuss how or why aged patients came to be admitted to Warneford and Littlemore asylums. Graeme Yorston and Camilla Haw, 'Old and Mad in Victorian Oxford: a Study of Patients Aged 60 and Over Admitted to the Warneford and Littlemore Asylums in the Nineteenth Century', *History of Psychiatry*, 16 (2005), pp. 395-421.

<sup>23</sup> Montigny, 'Foisted Upon the Government' p. 80.

<sup>24</sup> D. J. Mellett, *The Prerogative of Asylumdom: Social, Cultural, and Administrative Aspects of the Institutional Treatment of the Insane in Nineteenth-Century Britain* (New York, 1982), p. 159.

the difference between the two positions.<sup>25</sup> Historians on both sides of this supposed divide agree that people were institutionalised when their disruptive behaviour, to use Melling, Forsythe and Adair's terms, transcended the 'capacity and willingness' of people outside of institutions to cope with it. They agree that asylum patients had crossed a 'boundary of tolerance'; but disagree over precisely where this boundary lay.<sup>26</sup> This chapter is situated in the common ground between these two positions, arguing that families institutionalised their older relatives because they felt unable to cope. In his own attempt to reconcile his position with that of his critics, Scull suggested that 'manageability rather than the nature of an individual's mental defect' was decisive in the admission of an individual to the asylum.<sup>27</sup> Broadly speaking, this chapter draws the same conclusion.

### Old Age in the Family

The issue at stake in claiming that asylum patients were institutionalised because they were 'impossible' rather than 'inconvenient' is not why families chose to institutionalise their relatives, but how they felt about it. In 'Getting out of the asylum', David Wright suggested that the historiographic narrative of the 'rise of the affective family' might illuminate the family dynamics involved in institutionalisation, and the feelings which lay behind them.<sup>28</sup> This idea is particularly associated with historians Lawrence Stone and Phillipe Ariès, who have argued that the family became a more emotionally-centred unit over the course of the eighteenth and nineteenth centuries. This new type of family was held together by affection rather than material need.<sup>29</sup> This narrative has been applied to

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<sup>25</sup> Two recent examples of articles in this vein are Cathy Smith, 'Living with Poverty: Narratives of Poverty, Pauperism and Sickness in Asylum Records 1840-1876', in Andreas Gestrich, Elizabeth Hurren and Steven King (eds), *Poverty and Sickness in Modern Europe: Narratives of the Sick Poor, 1780-1938* (London, 2012), pp. 117-42; Steven J. Taylor, 'All his Ways are That of an Idiot': the Admission, Treatment of and Social Reaction to Two 'Idiot' Children of the Northampton Pauper Lunatic Asylum', *Family & Community History*, 15 (2012), pp. 34-43.

<sup>26</sup> This is a phrase used in Leonard Smith, *Cure, Comfort, and Safe Custody: Public Lunatic Asylums in Early Nineteenth Century England* (London, 1999), p. 96; Melling, Forsythe and Adair, 'Families, Communities and the Legal Regulation of Lunacy in Victorian England', p. 172.

<sup>27</sup> Andrew Scull, 'Rethinking the History of Asylumdom', in Joseph Melling and Bill Forsythe (eds), *Insanity, Institutions, and Society, 1800-1914* (London, 1999), p. 300.

<sup>28</sup> Wright, 'Getting out of the Asylum', p. 153.

<sup>29</sup> Philippe Ariès, *Centuries of Childhood* (Harmondsworth, 1973); Lawrence Stone, *The Family, Sex and Marriage in England, 1500-1800* (New York, 1977).



marriage, and to the relationship between parents and their young children, but has not included much discussion of the third generation, and the relationship of older parents with their adult children.<sup>30</sup> The Hanwell case notes underpinning this chapter, therefore, provide the opportunity to add some new historical insight to the bonds of duty and affection which tied adult children to their older parents, along with other members of the extended family.

As discussed in the Introduction to this thesis, much of the history of old age has been devoted to debunking the 'golden age' myth. This refers to a popular historical image of a past in which 'older people were venerated in their communities and cared for by their family'.<sup>31</sup> Demographic studies have thrown significant doubt on the idea that older parents lived with their adult children in pre-industrial England. In the 1960s, Historical demographer Peter Laslett suggested that household size in England remained fairly stable from the sixteenth to the late-nineteenth century at around 4.75 people, precluding a widespread pattern of multigenerational cohabitation.<sup>32</sup> Though he later came to place more emphasis on local variation, Laslett continued to stress 'the relative unimportance of extended family living for the historical experience of elderly people [in England]'.<sup>33</sup> Other demographic studies, however, have produced different results. Stephen Ruggles has suggested that extended family living – including the co-residence of multiple generations – was a significant feature of the demographic landscape of Victorian England.<sup>34</sup> Michael Anderson has undertaken small-scale studies of some

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<sup>30</sup> Stone briefly refers to this relationship, but does not integrate it into his overall narrative. Indeed, he suggests that, in the nineteenth century, adult children and their parents became 'strangers': Stone, *The Family, Sex and Marriage in England, 1500-1800*, pp. 403-4.

<sup>31</sup> Paul Johnson, 'Historical readings of old age and ageing', in Paul Johnson and Pat Thane (eds), *Old age from Antiquity to post-modernity* (London; New York, 1998), p. 2; Carole Haber, *Beyond Sixty-Five: the Dilemma of Old Age in America's Past* (Cambridge, 1983), p. 5; W. Andrew Achenbaum, *Old Age in the New Land: the American Experience since 1790* (Baltimore, 1978), p. 4; Susannah R Ottaway, *The Decline of Life: Old Age in Eighteenth-Century England* (Cambridge, 2004), p. 1; Richard Wall, 'Elderly Persons and Members of their Households in England and Wales from Preindustrial Times to the Present', in David I. Kertzer and Peter Laslett (ed.), *Aging in the Past: Demography, Society and Old Age* (Berkeley, 1995), p. 81.

<sup>32</sup> Peter Laslett, 'Size and Structure of the Household in England Over Three Centuries', *Population Studies*, 23 (1969), p. 200.

<sup>33</sup> Peter Laslett, *A Fresh Map of Life: the Emergence of the Third Age* (London, 1989), p. 114.

<sup>34</sup> Steven Ruggles, *Prolonged Connections: the Rise of the Extended Family in Nineteenth-Century England and America* (Madison, 1987), pp. 127-34.

industrial communities, and found that the 1850s saw high levels of multigenerational cohabitation in these areas, offering an important corrective to the historical commonplace that industrialisation fragmented the working-class family.<sup>35</sup> This extends to the overcrowded and supposedly fragmented metropolis of London. Richard Wall's studies of multigenerational cohabitation indicate that around 50 per cent of Londoners aged 65 or over in the 1880s lived with their children, although the proportion was slightly lower in inner-city Bethnal Green than in the more suburban Walthamstow and Pinner.<sup>36</sup> Interestingly, Wall's findings do not reveal any clear gender differentiation: in his detailed studies of the 1891 census, he found that almost equal numbers of men and women resided with their children.<sup>37</sup>

There has been significant disagreement among historians over the extent to which families have, historically, been held responsible for the support of their aged members. David Thomson has most vociferously argued that a tradition of communal support for the aged was established under the Old Poor Law, and survived the changes wrought by Poor Law reform in 1834.<sup>38</sup> Richard Smith has taken a different stance towards the role of the family in supporting aged members. He suggests that the support of adult children for their parents has been a common feature of English family relations at least as far back as the medieval period, but that this support was 'conditional' based on 'mutual advantage rather than duty'.<sup>39</sup> Pat Thane's assessments have generally been more optimistic about the role of the

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<sup>35</sup> Michael Anderson, 'Households, Families and Individuals: Some Preliminary Results from the National Sample from the 1851 census of Great Britain', *Continuity and Change*, 3 (1988), pp. 421-38; Michael Anderson, 'Household Structure and the Industrial Revolution: Mid-Nineteenth-Century Preston in Comparative Perspective', in Peter Laslett and Richard Wall (eds), *Households and Family in Past Time* (Cambridge, 1972), p. 223.

<sup>36</sup> Wall, 'Elderly Persons and Members of their Households', pp. 95-96.

<sup>37</sup> Wall, 'Elderly Persons and Members of their Households', pp. 95-96; Richard Wall, 'Elderly Widows and Widowers and their Coresidents in Late Nineteenth- and Early-Twentieth-Century England and Wales', *The History of the Family*, 7 (2002), pp. 139-55.

<sup>38</sup> David Thomson, 'I Am Not my Father's Keeper': Families and the Elderly in Nineteenth-Century England', *Law and History Review*, 2 (1984), pp. 266-76; David Thomson, 'The Welfare of the Elderly in the Past: a Family or Community Responsibility?', in Margaret Pelling and Richard Smith (eds), *Life, Death and the Elderly* (London, 1994), pp. 192-221.

<sup>39</sup> Richard Smith, 'Charity, Self-Interest and Welfare: Reflections from Demographic and Family History', in Martin Daunt (ed.), *Charity, Self-Interest and Welfare in the English Past* (London, 1996), p. 44.

family, suggesting that there has been a 'long continuity of a particular cultural tradition in intergenerational relations in English families'.<sup>40</sup> 'There was,' she argues, 'a strong sense of obligation to give what material and emotional support one could to elderly relatives, within reason'.<sup>41</sup>

Historians on both sides of this argument are agreed that the last 30 years of the nineteenth century was a 'distinctive' moment for the balance of responsibility between family and community, particularly when it came to aged dependents. From the 1870s, Poor Law Unions around the country introduced measures designed to restrict and reduce the provision of Poor Law support.<sup>42</sup> This so-called 'crusade against out-relief' included the 'vigorous[] pursu[ing]' of family members who were considered 'liable' in the assistance of their aged relatives.<sup>43</sup> According to Thomson, the definition of a liable relative also expanded significantly in this period, to include siblings, nieces, nephews, and even friends.<sup>44</sup> At the end of the nineteenth century, then, the idea of family support for the elderly was culturally legitimated, legally reified and, increasingly for those pursued by Poor Law crusaders, a social reality. Yet this situation is only of limited applicability to the aged discussed in this chapter. The crusade was focussed on material support, in the form of direct financial contributions. What the patients who eventually arrived at Hanwell needed was practical support. Smith argues that an assessment of these more dependent caring relationships is the next major frontier in the history of the family: 'The real problem that has yet to be confronted by historians of welfare and the family is how far support was given when the element of mutuality was absent'.<sup>45</sup> This chapter argues that, where mentally disordered older people were concerned, Pat Thane's optimistic assessment of the family as an essentially supportive unit is borne out. The adult children in the Hanwell sources often

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<sup>40</sup> Pat Thane, *Old Age in English History: Past Experiences, Present Issues* (Oxford, 2000), p. 11.

<sup>41</sup> Pat Thane, 'Old People and their Families in the English Past, in Daunton (ed.), *Charity, Self-Interest and Welfare*, p. 134.

<sup>42</sup> Elizabeth T. Hurren, *Protesting about Pauperism: Poverty, Politics and Poor Relief in Late-Victorian England, 1870-1900* (Woodbridge, 2007), pp. 59-76.

<sup>43</sup> Thane, *Old Age in English History*, pp. 171-73.

<sup>44</sup> Thomson, 'I Am Not my Father's Keeper': Families and the Elderly in Nineteenth-Century England', p. 278.

<sup>45</sup> Smith, 'Charity, Self-Interest and Welfare', p. 44.

expressed a sense of obligation to offer care and support to their older parents, even when they were unable to fulfil it. This sense of obligation spread beyond the immediate nuclear family: siblings, nieces, nephews and friends stepped in to offer practical, emotional and financial care and support where they could.

The strains of industrialisation and urban living, then, did not sever family ties. The ideal of family support, however, was often unfulfilled, and older people often fell on the Poor Law for maintenance. Late-nineteenth-century studies of urban and aged poverty revealed that a high proportion of people aged 65 and over received Poor Law relief: between 20 and 30 per cent.<sup>46</sup> As discussed in the Introduction, this proportion was higher in London, and significantly weighted towards indoor relief in the workhouse.<sup>47</sup> The workhouse did not just offer material support to impoverished older people, but a level of medical care to those who were infirm.<sup>48</sup> The workhouse, then, played a significant role in the lives of many aged Londoners.

The workhouse also played an important role in the lives of insane Londoners. Almost every single one of the patients in these case notes passed through the workhouse on their way to the asylum. Some of these were among the large proportion of aged Londoners who found themselves in the workhouse due to poverty and infirmity, and developed mental symptoms after their admission. Others were sent to the workhouse in response to the appearance of mental symptoms. The workhouse was generally used as a sorting house for lunatics in nineteenth-century London: Elaine Murphy, in her study of mid-nineteenth century East London Poor Law Unions, found that the Poor Law relieving officer brought suspected cases of insanity into the workhouse in the first instance. The decision over whether to admit to the asylum was made there, often after an extended period of observation.<sup>49</sup> The events described by Murphy seem to reflect

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<sup>46</sup> George R. Boyer and Timothy P. Schmidle, 'Poverty Among the Elderly in Late Victorian England', *The Economic History Review*, 62 (2009), p. 249.

<sup>47</sup> See p. 9.

<sup>48</sup> The medical function performed by the workhouse is well-known, but little-studied. See the essays in Jonathan Reinarz and Leonard Schwarz, *Medicine and the Workhouse* (Rochester, 2013).

<sup>49</sup> Murphy, 'The Lunacy Commissioners and the East London Guardians, 1845-1867', p. 513.

the process by which almost all of the patients in this study came to Hanwell. This chapter, then, will therefore take seriously Elaine Murphy and Peter Bartlett's claims that we should see Poor Law officials, and the workhouse, as central to the asylums' admission process.<sup>50</sup> The medical certificates of these patients often contained evidence from workhouse nurses and attendants. In these cases, the needs and interests of the workhouse were clearly more important in the decision to admit someone to the asylum, than those of the family. In this way, the officials, officers and attendants of the workhouse were often the 'real agents' in the admission of aged patients to Hanwell.

The rest of this chapter is about unmanageable people moving through a series of regimes of management – different homes, charitable institutions, the workhouse – before they are finally sent to the institution whose assigned purpose was to manage and contain this disruption. It contains three main sections. The first looks at the marital, familial, and friendly relationships revealed through the asylum case notes and dynamics of obligation and affection which underpinned these relationships. It asks who cared for these patients prior to their institutionalisation, and why they did so. The second section considers the practices of care which were enacted outside of the asylum, and the way that families in particular responded to and attempted to manage the patient's mental disturbance. This includes their response at the moment in which these care relationships became overwhelmed, when the decision to institutionalise was made. The final section looks at the workhouse in particular, and considers the way that the needs and limitations of that institution drove the admissions process. It was the status of an old person as 'unmanageable' which led to and legitimised their admission to the asylum.

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<sup>50</sup> Bartlett, *The Poor Law of Lunacy*, p. 2; Murphy, 'The Lunacy Commissioners and the East London Guardians, 1845-1867', p. 495.

## Relationships and Care Before Institutionalisation

### *Troublesome Husbands, Troubled Wives*

The networks of affection and obligation which underpinned caring relationships outside of the asylum were complicated and varied. This section will examine these relationships, beginning with marriages. A third of the patients aged 60 or over in this sample were married at the time of their admission. When viewed from the perspective of marriage, a highly gendered picture of the experience and representation of insanity in old age emerges. In both the male and female case notes, marital relationships are described in the same way: husbands are troublesome and wives are troubled.

The male case notes contain stories of wives who cared for their husbands despite significant mistreatment. The wife of 60-year-old Robert Baker described him as ‘an unkind husband’, and she told the doctors at Hanwell that she feared his tempers. Yet she had nursed him for ten years while his health was failing.<sup>51</sup> William Ford’s wife described him as ‘artful, scheming...and devoid of affection for his children’. She left him in 1878, 14 years prior to his admission, ‘owing to his violence’. However, in 1890 he sent her a message to say that he was planning to commit suicide, and she returned, apparently staying with him for the two years leading up to his institutionalisation.<sup>52</sup> These cases both undermine any inclination to see the caring relationships described in these case notes in a sentimental light. Though we do not know the complexities of the emotions and experiences which lay behind these wives’ decisions to care for their apparently abusive husbands, we do know that they were made in a social and cultural context which gave few options to women in abusive relationships. Both of these institutionalisations took place at an important moment in the history of marital conflict, occurring in the aftermath of the 1891 *R. v. Jackson* decision, which unambiguously deprived husbands of the legal right physically to coerce their wives.<sup>53</sup> This can be seen in the

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<sup>51</sup> Robert George Baker, Hanwell Casebook, Males No. 13, H11/HLL/B20/22 (1892), p. 19.

<sup>52</sup> William Ford, Hanwell Casebook, Males No. 12, H11/HLL/B/20/021 (1891), p. 505.

<sup>53</sup> A. James Hammerton, *Cruelty and Companionship: Conflict in Nineteenth-Century Married Life* (London, 1992), p. 106.

context of a longer-term increase in legal support for the wives of violent husbands, and in the public interest in spousal abuse.<sup>54</sup> William Ford's wife had, in the past, taken advantage of this legal-cultural shift, and shown significant resistance and tenacity in leaving him to raise her children alone. However, both of these women continued to care for (or, at least, tolerate) their abusive spouses during their mental deterioration. This supports Maeve Doggett's claim that there was little genuine change in the overall patriarchal ideals of marriage, or in the day-to-day experience of marriage for working-class women.<sup>55</sup> The care and tolerance of these wives, then, can be seen as expressions of the cultural expectations and social limitations which exhorted female victims of spousal violence to continue to perform their wifely domestic duties.<sup>56</sup>

Not every male patient had a noted history of abuse. But the broader theme, of husbands causing trouble to their wives, appears repeatedly in the case notes on both sides of the asylum. When a patient's marriage was mentioned in the male case notes, it was discussed in terms of the *effect* the patient's insanity had had on their marital relationship and their spouse. When the wife of John Dodge came to Hanwell in 1892, and explained that he had been 'very violent and irritable' for the previous two years, the doctor taking her account noted that John had been 'a constant source of anxiety to his wife'.<sup>57</sup> William Dawes' wife stated simply that 'she was afraid of him'.<sup>58</sup> When a female patient's marriage was mentioned in the case notes, however, it was usually described as a *cause* of her mental disorder. Jane Glove and Sophia Leach were both married when they entered Hanwell in 1871 and 1892 respectively. Yet it was their friends, rather than their husbands, who came to Hanwell to narrate their case. Jane Glove's friend told the doctors that her husband was 'a dissolute fellow and never treated her very well'. He had, according to the friend, sent her to the workhouse when her symptoms had first appeared, and had

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<sup>54</sup> Maeve E. Doggett, *Marriage, Wife-Beating, and the Law in Victorian England* (Columbia, 1993), pp. 1-4.

<sup>55</sup> Doggett, *Marriage, Wife-Beating and the Law*, pp. 142-48.

<sup>56</sup> Ellen Ross, "'Fierce Questions and Taunts': Married Life in Working-Class London, 1870-1914", *Feminist Studies*, 8 (1982), pp. 591-92; Hammerton, *Cruelty and Companionship*, pp. 43-45.

<sup>57</sup> John Dodge, H11/HLL/B/20/022 (1892), p. 47.

<sup>58</sup> William Dawes, Hanwell Casebook, Males No. 30, H11/HLL/B/20/039 (1911), p. 189.

not seen her at all in the 18 months since.<sup>59</sup> Sophia Leach's friend explained that she was 'at times very badly treated by her husband' and that he used to 'knock [her] about'. Sophia had obtained a legal separation from her husband at some point in the indeterminate past, but this did not preclude her friend – with whom she had previously been living – from speculating that his mistreatment was the cause of her insanity.<sup>60</sup> A husband did not have to be cruel or violent to place a strain on his wife. When Hannah Holder was admitted to the asylum, her daughter claimed that her insanity was caused by the burden of caring for her ill husband. The husband himself declined to come to the asylum to narrate her case, being 'but a working man'.<sup>61</sup>

The prominence of troublesome husbands in Hanwell case notes may be a reflection of the social reality of nineteenth-century marriage. Social historians of the family have suggested that nineteenth-century marital norms gave a particularly raw deal to working-class women, where 'the wife served as a buffer for her husband'.<sup>62</sup> Women, of course, were not always docile sufferers. Elizabeth Case had broken two of her husband's ribs, and 'went after him with pokers' prior to her institutionalisation. In response to this, her husband had applied to a magistrate to have her 'bound over to a House of Detention' to protect him from her violence. When she was released, she went straight to the workhouse, instead of his home. Elizabeth Case's husband, then, does not seem to have been bound by the same obligation of care as the wives of Robert Baker or William Ford. Together, these cases suggest that a burden of care fell on wives which did not fall on husbands, even if they had been significantly mistreated. Many contemporary commentators also remarked that working-class husbands were as much a burden as a protection to their wives. In an analysis of the reform literature published on

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<sup>59</sup> Jane Elizabeth Glove, Hanwell Casebook, Females No. 21, H11/HLL/B/19/021 (1871), p. 249.

<sup>60</sup> Sophia Leach, Hanwell Casebook, Females No. 15, H11/HLL/B/19/038 (1892), p. 118.

<sup>61</sup> Hannah Holder, H11/HLL/B/19/021 (1872), p. 353.

<sup>62</sup> Joan Scott and Louise Tilly, 'Women's Work and the Family in Nineteenth-Century Europe', in Charles E. Rosenberg (ed.), *The Family in History* (Philadelphia, 1975), pp. 172-73; Peter N. Stearns, 'Working-Class Women in Britain, 1890-1914', in Martha Vicinus (ed.), *Suffer and be Still: Women in the Victorian Age* (Bloomington, 1973), pp. 117-18; Laura Oren, 'The Welfare of Women in Labouring Families: England, 1860-1950', in Lois Banner and Mary Susan Hartmann (eds), *Clio's Consciousness Raised: New Perspectives on the History of Women* (New York, 1976), p. 240.



the topic of domestic violence in the second half of the nineteenth century, historian James Hammerton found that middle-class writers generally placed the blame for marital strife amongst the lower orders firmly on the men. Reformers and writers of all political stripes – traditionalists who sought to strengthen the family by encouraging the paternal authority of the husband, and feminists who wanted to redress gender inequality – found that ‘the misconduct of poor working-class men provided fertile ground for analysis, protest and reform.’<sup>63</sup> The doctors who elicited and recorded these narratives, then, were reproducing this discourse which problematised the working-class husband.

For both men and women, widowhood could be a significant spur to admission on the road to the asylum. Grief at the death of a spouse was often cited as a cause of insanity. Frederick Allen’s daughter explained that he had ‘shown no symptoms of insanity’ until the sudden death of his wife three years previously, which ‘so upset him that...he became restless...in the middle of the night [and] soon developed delusions of persecution’.<sup>64</sup> This cause could be given, even if the bereavement occurred some time before the appearance of mental disorder. The death of Mary Carter’s husband was recorded as the cause of her insanity, despite the fact that it occurred over a year before her ‘excited’ and ‘troublesome’ behaviour began.<sup>65</sup> The emotional impact of this event was often compounded by a financial one. Widowhood could have significant repercussions for the domestic economy of care. When Sarah Mitchell’s husband died in early 1892, her son also lost his job, leaving their small household without an income. The economic uncertainty of this – along with her grief – was cited as the cause of both her insanity and her institutionalisation, as her son was left without the means to support her or himself.<sup>66</sup> Mary Ann May had apparently been ‘eccentric in habits and in very bad health’ for a long time before her institutionalisation, and her husband had apparently cared for her. Following his death in June 1872, she was not only left without a care-giver, but she also experienced a significant escalation in her mental

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<sup>63</sup> Hammerton, *Cruelty and Companionship*, pp. 66-67.

<sup>64</sup> Frederick Allen, H11/HLL/B/20/021 (1891), p. 297.

<sup>65</sup> Mary Carter, H11/HLL/B/19/021 (1872), p. 69.

<sup>66</sup> Sarah Mitchell, H11/HLL/B/19/038 (1892), p. 184.

symptoms. Her niece – who appears on her certificate – apparently had neither the means nor the inclination to take responsibility for her care, and she entered Hanwell six weeks later.<sup>67</sup> The association of widowhood with pecuniary strife was so strong, that it entered the delusory world view of one patient. Francis McLevy – a man of some means – drove to the workhouse in a phaeton carriage immediately following the death of his wife, because he ‘felt himself destitute’. He was swiftly certified and sent to Hanwell.<sup>68</sup>

### *Adult Children and the Extended Family*

As discussed above, the level of obligation felt by adult children towards their older parents has been a matter of some historiographic and contemporary disagreement. For the most part, the evidence in Hanwell’s case notes supports Pat Thane’s assertion that, in nineteenth-century England, ‘there was a strong sense of obligation to give what material and emotional support one could to elderly relatives’.<sup>69</sup> Only a small proportion of the patients in this sample can be identified as living in a multigenerational household prior to their institutionalisation. However, as Thane has emphasised, cohabitation is only one means of offering support. Many relatives who did not reside with the patient visited them at the asylum after their admission, and were able to give a detailed account of the patient’s life, suggesting significant and sustained contact. The letters written by families who could not visit the asylum are often apologetic in tone, and express a sense of unfulfilled obligation. Hanwell’s case notes suggest that a pervasive sense of social and moral obligation encouraged families to take care of their aged family members where possible, but that the realities – economic, physical, emotional – of working-class family life in the metropolis meant that their ideal could not be realised.

Some adult children did respond to their parents’ mental deterioration by bringing them to live with them. According to the narratives, a wide variety of symptoms and situations could trigger this cohabitation arrangement: Susan

<sup>67</sup> Mary Ann May, Hanwell Casebook, Females No. 22, H11/HLL/B/19/022 (1872), p. 231.

<sup>68</sup> Francis McLevy, Hanwell Casebook, Males No. 11, H11/HLL/B/20/011 (1872), p. 449.

<sup>69</sup> Thane, ‘Old People and their families in the English Past’, p. 99.

Woolley's son took her in because 'her strength was beginning to fail'; Honor Stafford was taken in by her widowed daughter following a 'stroke of paralysis'; Elizabeth Grey was 'brought up to London' by her son because she was hallucinating ghostly figures in her garden.<sup>70</sup> Some of these arrangements were only meant to be short-term, as in the case of George Brown. His symptoms were quite severe, including violence, threats of suicide, delusions of suspicion, shouting on street corners and grandiose pronouncements of his ability to save passers-by from Hell. In response to this, his daughter brought him to live with her. After only three weeks, he had sufficiently recovered to return to his former abode, and to his job at a factory. However, he quickly deteriorated again, attempted suicide, and was taken to the workhouse.<sup>71</sup> For George Brown's daughter, then, this cohabitation arrangement was a short-term response to her father's acute problems, but not a long-term relationship of care. She could give him the space to recover, but it was expected that he would return to his independent existence.

Unlike George Brown and his daughter, most of the multigenerational cohabitations described in the case notes were long-term arrangements. Honor Stafford's widowed daughter and granddaughter cared for her for seven years while her capacities deteriorated until, aged 84, she had 'scarcely a vestige of mind' left, and went to the infirmary.<sup>72</sup> Richard Cullen lived with his son for 'a long time' according to the narrative in his case notes, during which time 'medical aid was resorted to at home', in an attempt to deal with his wandering, confusion and incontinence.<sup>73</sup> Elizabeth Grey had lived with her son and daughter-in-law for five years prior to her institutionalisation, during which time she posed significant challenges to them, 'always getting into mischief'.<sup>74</sup> William Sadler's son wrote to the asylum to say that he had not seen his father for nine years, but that prior to that they had lived together for several years during periods of 'brain disturbance'. William's 'extravagance' eventually made this living arrangement untenable, but

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<sup>70</sup> Susan Woolley, Hanwell Casebook, Females No. 5, H11/HLL/B/19/004 (1852), p. 75; Honor Stafford, H11/HLL/B/19/037 (1892), p. 589; Elizabeth Grey, H11/HLL/B/19/038 (1892), p. 34.

<sup>71</sup> George Brown, Hanwell Casebook, Males, No. 10, H11/HLL/B/20/010 (1871), p. 239.

<sup>72</sup> Honor Stafford, H11/HLL/B/19/037 (1892), p. 589.

<sup>73</sup> Richard Cullen, H11/HLL/B/20/010 (1871), p. 111.

<sup>74</sup> Elizabeth Grey, H11/HLL/B/19/038 (1892), p. 34.

his son's family had shown significant forbearance in the face of his difficult behaviour: they were 'sold up' on three occasions, due to his expansive spending, before they sent him to live elsewhere.<sup>75</sup> These cases, then, support the argument that the admission of an aged patient to the asylum was not necessarily a sign of abandonment and isolation. They show that some families took it upon themselves to provide 'a great deal of care for their aged kin', and that they endured significant emotional and financial hardships in order to maintain these caring relationships.<sup>76</sup>

The role of gender in these cohabitational arrangements is uncertain. In his study of the lives of *The Aged Poor in England and Wales*, Charles Booth claimed that women were far more frequently taken in by their adult children, because they were 'more useful in the home'.<sup>77</sup> Booth's assessment has been echoed by historians Peter Stearns and Victor Bailey, who have argued that women were more firmly embedded in the social and emotional networks of family and community, better versed in the domestic tasks which might make them more useful in the household, and more 'psychologically accustomed to dependency' than men.<sup>78</sup> However, more recent historical work has complicated this gendered picture. Richard Wall's demographic studies have suggested that older men and women were equally likely to live with their adult children in the nineteenth and early-twentieth centuries. The 'stock figures' of the 'coresident spinster sister and widowed mother' are not present in Hanwell's case notes.<sup>79</sup> The examples of multigenerational cohabitation described above show that both men and women were taken in by their adult children, in response to mental deterioration or disorder.

This does not, of course, mean that these caring relationships were unaffected by gender. The men in this sample were less likely to fall upon their children for care, because they were more likely to have a living spouse: just over half of the men in this sample were married at the time of their admission,

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<sup>75</sup> William Sadler, Hanwell Casebook, Males No. 31, H11/HLL/B/20/040 (1911), p. 23.

<sup>76</sup> Montigny, 'Foisted Upon the Government', p. 819.

<sup>77</sup> Charles Booth, *The Aged Poor in England and Wales* (London, 1894), p. 142.

<sup>78</sup> Victor Bailey, *'This Rash Act': Suicide Across the Life Cycle in the Victorian City* (Stanford, 1998), p. 98; Peter N. Stearns, 'Old Women: Some Historical Observations', *Journal of Family History*, 5 (1980), p. 53.

<sup>79</sup> Ruggles, *Prolonged Connections*, p. 131.

compared to less than a quarter of the women. This is consistent with wider patterns of marital status in London during the second half of the nineteenth century, and reflects the abiding mortality gap: in the nineteenth century, as in the present, wives usually outlived their husbands.<sup>80</sup> Sons and daughters both took their elderly parents into their homes prior to their institutionalisation, and both sons and daughters went to Hanwell to narrate their parents' case histories. The gendered realities of care relationships, however, were hardly likely to have been egalitarian. In her studies of the family and community in Victorian East London, Ellen Ross went so far as to suggest that men and women's 'daily responsibilities [were] so separate that they failed to grasp the major concerns of each other's lives'.<sup>81</sup> It was Elizabeth Grey's son who went to Hanwell to narrate her case, and it was he who had apparently made the decision to bring her to live with his family. Yet the census shows that he was fully employed as a 'glass warehouseman', leaving his wife to provide the 'constant looking after' than Elizabeth reportedly required. His description of Elizabeth's behaviour contains certain specific details – 'putting an empty kettle on the fire, putting the milk into the sugar' – which suggest that her son was not entirely clueless as to what was going on in the home.<sup>82</sup> Yet the case notes offer no indication as to how his wife felt about her primary caring role.

These narratives of adult children taking in their aged parents in response to their mental troubles, do not represent the typical experience of Hanwell's aged admissions. In cases where children did not provide this type of care, however, there are indications that they considered themselves to be acting against the social ideal. The case notes contain letters from patients' children, explaining why they could not visit the asylum or undertake the care of their parents. Illness or financial burdens were given as reasons. Elizabeth Wells' daughter wrote that she had 'no means to visit so far I am a widow with one child'.<sup>83</sup> Ann Crossman's daughter

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<sup>80</sup> Thane, *Old Age in English History*, pp. 21-24.

<sup>81</sup> Ellen Ross, 'Survival Networks: Women's Neighbourhood Sharing in London before World War I', *History Workshop Journal*, (1983), pp. 4-27.

<sup>82</sup> Elizabeth Grey, H11/HLL/B/19/038 (1892), p. 34.

<sup>83</sup> Elizabeth Wells, H11/HLL/B/19/037 (1892), p. 283.

wrote that she 'should have been to see you about my poor mother, only I have not been well.' She assured the medical officers that she would 'come down as soon as ever I can for I long to see her', but this promised visit never transpired.<sup>84</sup> Lydia Gaston's son wrote that he could not 'afford the expense of the journey to see you with regards to my poor mother, being a working man'. He explained that he would like to care for his mother himself, but that circumstances prevented it: 'I am unable to keep her myself or I should have had her with me, but my wife being delicate I fear I should have increased the troubles I already have to contend with'.<sup>85</sup> Leonard Smith has interpreted these types of letters as evidence of the 'apparent need for relatives to ventilate and confide their own difficulties to the medical superintendent'.<sup>86</sup> Catharine Coleborne has suggested that we see such letters as an 'emotional performance', laying out private feelings in the hope of gaining external approval.<sup>87</sup> Interpreted either way – as emotional performance of love for their parents, or as an act of strategic disclosure – these letters point towards a shared understanding of familial duty. These adult children felt the need to make explicit their concern for their 'poor' parents. They were compelled to explain the straightened circumstances which prevented them from caring for or visiting them. The apologetic tone of these letters contains an implicit request for forgiveness, for failing to fulfil the ideal social role. Many children did not undertake the care of their aged parents when they showed signs of mental deterioration, but these letters suggest that many people thought that they should.

It was not just children who felt and fulfilled this obligation of care. The case notes contain examples of siblings, nieces and nephews who brought their aged relatives to live with them. When Richard Hicks entered the asylum in 1911, his sister informed one of the medical officers that she had been concerned about his isolation following the death of his wife. When she noticed his memory getting bad, she had initially arranged for him to live with her son, who was himself

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<sup>84</sup> Ann Crossman, H11/HLL/B/19/023 (1872), p. 173.

<sup>85</sup> Lydia Gaston, H11/HLL/B/19/037 (1892), p. 304.

<sup>86</sup> Leonard Smith, 'Your Very Thankful Inmate': Discovering the Patients of an Early County Lunatic Asylum', *Social History of Medicine*, 21 (2008), p. 241.

<sup>87</sup> Catharine Coleborne, 'Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, c. 1880–1910', *Social History of Medicine*, 19 (2006), p. 437.

married with two young children. This arrangement, however, quickly proved unsustainable, and Richard was sent to the infirmary.<sup>88</sup> Sarah Townsend, the woman whose experiences were discussed at the beginning of this chapter, was also well embedded within a wider familial network. After her transfer to Hanwell, her family wrote letters requesting more information about Sarah's condition, imploring the medical officers to continue the 'kindness' extended to her at Lancaster Asylum, and asking how soon they could visit. Sarah's family, then, showed little desire to 'get rid of her', indeed, they expressed significant anxiety that her care had passed out of their control.<sup>89</sup>

It was Sarah's sisters and brother-in-law who had stepped in to bring her into their homes, and who subsequently wrote to the asylum asking for details of her case. It was her nephew, however, who gave the evidence of insanity which is included on her medical certificate. This suggests that he was the one who solicited this institutionalisation, at odds with the wishes of the concerned older generation. While his mother wrote in a letter that Sarah 'seemed to me to be sensible and rational', Sarah's nephew informed the certifying doctor that she 'becomes violent and tries to bite when restrained'.<sup>90</sup> Their differing accounts remind us that families are not unified entities; they contain members with competing and conflicting interests. The case history narratives were solicited by a circular letter, sent to a patient's nearest known relative soon after their admission. This letter, however, might pass between several hands before a response was sent. Lydia Gaston's son, who wrote one of the apologetic letters discussed above, lived in Plymouth. He had been sent the Hanwell circular by a brother who lived much closer to the asylum, in London. The son who responded could not afford to travel to Hanwell; the son who did not respond apparently did not care to.<sup>91</sup> The anxiety caused by cruel, inconsiderate, or otherwise disappointing children was sometimes named in the case notes as the cause of an older patient's insanity. The medical officer who recorded the case history narrative for 80-year-old Richard Plumb, supplied by his

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<sup>88</sup> Richard Hicks, H11/HLL/B/20/040 (1911), p. 63.

<sup>89</sup> Sarah Townsend, H11/HLL/B/19/037 (1892), p. 271.

<sup>90</sup> Sarah Townsend, H11/HLL/B/19/037 (1892), p. 271.

<sup>91</sup> Lydia Gaston, H11/HLL/B/19/037 (1892), p. 304.

sister, reported that 'it seems likely that his children have not behaved well to him', and pointed to their lack of support as a cause of his insanity.<sup>92</sup> James Rourke's insanity was supposedly caused by his awareness that his family could not support him and his wife, and his fears of having to rely on the Poor Law for support: 'two of his children being in America, the others dead but one, a seamstress in London barely able to support herself, there was no one left to assist them, he was constantly brooding over this condition'.<sup>93</sup> These examples offer a useful reminder that, while kinship networks could offer real support to older people, they were also inconsistent. The social ideal that children would care for their parents, then, was not overwhelming: individual circumstances, relationships and personalities could easily override it.

Where supportive familial relationships were in place, they did not end at the point of institutionalisation. Letters written to the medical officers offer some indication of the way that friends and family members continued to take responsibility for the experience of their loved ones within the asylum walls.<sup>94</sup> One of the main concerns of these families was to ensure that their loved ones maintained a good position, and some kind of social standing, within the large, anonymous institution. One of Sarah Townsend's sisters, and one brother-in-law, wrote to the asylum, asking that she 'be allowed to wear her own clothes'. In his letter, the brother-in-law made a point of remarking that 'we are paying 8/9 per week for her maintenance'. Sarah Townsend was one of the very few non-pauper patients in this sample, and her family made it clear that the distinction between her and her fellow inmates should be respected.<sup>95</sup> William Baggott's brother, Thomas Baggott, sought distinction for him in a very different way. When William was admitted to Hanwell, Thomas was an inmate of Banstead Asylum. He dictated a coherent and sincere letter to a fellow patient, offering some details of William's life,

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<sup>92</sup> Richard Plumb, H11/HLL/B/20/021 (1891), p. 553.

<sup>93</sup> James Rourke, H11/HLL/B/20/010 (1871), p. 191.

<sup>94</sup> Louise Wannell, 'Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875–1910', *Social History of Medicine*, 20 (2007), p. 297.

<sup>95</sup> Sarah Townsend, H11/HLL/B/19/037 (1892), p. 271.



and sent it to Hanwell. The letter ended with a testament of his brother's good character, and a supplicating request for good treatment:

He has been a hard working man and is not other than poor at present, so that I trust you will find him a worthy recipient of the good things distributed to such persons under your generous supervision.

Thomas' letter offers us a patient's view of the asylum regime, in which being regarded as a 'worthy' patient was paramount. By describing his brother as 'hard working' and 'not other than poor', he implied that idle patients, suspected of vices beyond poverty, would receive worse treatment in the asylum. He suggests that it was in power of the superintendent's own 'generosity' to distribute 'good things' to deserving patients. Thomas Baggott's letter thus portrays the asylum as a strictly disciplinary institution, in which 'worthy' behaviour is rewarded. At the same time, these letters point to a level of flexibility within this regime. William and Sarah's families were making attempts to shape their relative's individual experience of the asylum regime, using the very different means at their disposal. Sarah Townsend's family used their financial position, and Thomas Baggott used his personal knowledge of asylum life, and the deferential tone he had learned to adopt there.

Stephen Ruggles' survey of nineteenth-century advice literature has revealed an idealised version of family, in which the sentimentalised bonds of the nuclear home were extended to more peripheral kin. 'The advice books,' he reports, 'are full of admonitions regarding the "duties of brothers and sisters" and the "obligations" of married children to their elderly parents.'<sup>96</sup> The evidence presented here suggests that this ideal was more than just a middle-class fantasy. Many poorer families desired and pursued a situation in which they could care for their aged kin. Clearly, this sense of obligation did not weigh on everyone, and the ideal of intergenerational support was often unobtainable. This situation did not have to mean neglect and isolation. When families proved unwilling or unable to provide

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<sup>96</sup> Ruggles, *Prolonged Connections*, p. 131.

care for their older relatives, Hanwell's cases notes show that friends and charitable organisations could also feel compelled to step in.

### *Friendship, Neighbourhood and Charity Networks*

Historians Pat Thane and Susannah Ottaway have both concertedly challenged the assumption that an independently-dwelling old person in the past was necessarily 'neglected and isolated'. They emphasise the desirability of independence as a consistent feature of older English people's lives, at least as far back as the eighteenth century. This independence, they suggest, was not absolute, but 'negotiated', combining resources gained through work, Poor Law and community support, and the family.<sup>97</sup> This chimes with a wider interest in the history of the family over the last 30 years in non-cohabitational kinship.<sup>98</sup> Historians of working-class Victorian London have emphasised the importance of neighbourhood support networks in times of crisis and difficulty, such as childbirth, illness and old age. Furthermore, '[n]eighbourhood relationships in many London districts overlapped with kinship'.<sup>99</sup> Many of the patients in this sample were living independently prior to their institutionalisation, but were embedded within these wider networks of kinship and social support. Elizabeth Lethbridge, widowed 20 years prior to her admission to Hanwell in 1871, is one such case. She had supported herself as a domestic servant, with supplementary assistance from friends by whom she was 'loved and respected'. Well into her seventies, she was the very model of a successful, independent older woman, enjoying a negotiated independence. Immediately prior to her institutionalisation, she had been lodging in the home of a furniture salesman and his family. Though not related, they were apparently happy for her to remain there in the two years leading up to her admission, during which time she had reportedly been hearing voices. Though she lived apart from her family, she was clearly not estranged from them; her sister was able to give a

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<sup>97</sup> Thane, *Old Age in English History*, pp. 123, 434, 480; Ottaway, *The Decline of Life*, p. 1.

<sup>98</sup> Barry Reay, 'Kinship and the Neighborhood in Nineteenth-Century England: the Myth of the Autonomous Nuclear Family', *Journal of Family History*, 21 (1996), pp. 87-104; Zvi Razi, 'The Myth of the Immutable English Family', *Past & Present*, 140 (1993), p. 3-44; David Warren Sabean, Simon Teuscher and Jon Mathieu, *Kinship in Europe: Approaches to Long-Term Developments (1300-1900)* (New York, 2007).

<sup>99</sup> Ross, 'Survival Networks: Women's Neighbourhood Sharing in London before World War I', p. 9.

detailed account of the development of her condition when she came to Hanwell.<sup>100</sup> Harriet Smith, also, was living alone in two rooms in a multi-household dwelling, when a possible suicide attempt prompted friends to 'take charge of her' – an arrangement which lasted over a year before she became 'unmanageable'.<sup>101</sup>

Charitable institutions provided support and care in lieu of family or friends. Six patients in this sample came to Hanwell from a charitable institution. In October 1911, William Sadler, whose extravagant behaviour had apparently made him impossible to live with, was admitted to Hanwell from Rowton House in Hammersmith. This was one of a series of hostels set up in the 1890s by philanthropist Lord Rowton, dedicated to providing cheap housing for down-and-out men.<sup>102</sup> The Rowton House had apparently provided a stable home for William for a significant portion of the time after his son removed him from his home, though eventually his behaviour proved too disruptive and he was removed to the asylum.<sup>103</sup> Five patients came from Catholic homes specifically set up for the care of the aged poor. Such homes, run by orders of nuns, have been described by historian Carmen Mangion as a 'novel and integral part of the framework of the mixed economy of welfare in the nineteenth century and an important alternative to poor-law workhouses'.<sup>104</sup> Four of these patients came from St Joseph's Home for the Aged Poor, in Notting Hill in West London. St Joseph's was opened in 1869 by the Little Sisters of the Poor, a French order of nuns who were established specifically to care for the aged. By the early 1870s, it was quite an operation, housing over 200 inmates, and 'giving an impression of a large workhouse hospital'. In spite of its mission as a home for the aged, contemporary journalistic accounts suggest that it was largely populated by the healthy, younger aged, with

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<sup>100</sup> Elizabeth Lethbridge, Hanwell Casebook, Females No. 20, H11/HLL/B/19/020 (1871), p. 229.

<sup>101</sup> Harriet Smith, Hanwell Casebook, Females No. 39, H11/HLL/B/19/062 (1911), p. 55.

<sup>102</sup> Michael Sheridan, *Rowton Houses 1892-1954* (London, 1956); Jane Hamlett and Rebecca Preston, 'A Veritable Palace for the Hard-Working Labourer?' Space, Material Culture and Inmate Experience in London's Rowton Houses, 1892-1918', in Jane Hamlett, Lesley Hoskins and Rebecca Preston (ed.), *Residential institutions in Britain, 1725-1970: Inmates and Environments* (London, 2013), pp. 93-107.

<sup>103</sup> William Sadler, H11/HLL/B/20/040 (1911), p. 23.

<sup>104</sup> Carmen M. Mangion, 'Faith, Philanthropy and the Aged Poor in Nineteenth-Century England and Wales', *European Review of History*, 19 (2012), p. 517.

the very old confined to the infirmaries, presenting 'truly a terrible sight'.<sup>105</sup> Mangion argues that the Catholic homes were prepared to offer medical care to the type of decrepit and incurable patients who would not have been admitted to voluntary hospitals.<sup>106</sup> The case notes of one Hanwell patient, however, suggest that the Little Sisters' tolerance for mental infirmity and behavioural disruption was rather more limited. Agnes Ryder was admitted to Hanwell in 1911, at the age of 62, from Kensington Infirmary, having been sent there from St Joseph's. Her medical certificate stated that she was 'constantly talking nonsense, singing, and disturbing others'. Upon her admission, however, the doctors found her to be quite rational and calm, and soon wrote to St Joseph's, asking that she might return. They replied that she could not, fearing that she would deteriorate again as others had done in the past. 'We had an old man for a time,' they wrote, 'who also got well, but did not last long and got quite bad again in very short time.' Agnes was discharged, a month after her admission to Hanwell, to the workhouse infirmary. Happily, another letter is included in her case note, from Agnes herself, informing the medical superintendent Dr Baily that she had made her way back to St Joseph's, and inquiring after some of her fellow patients. It appears that she was never readmitted to Hanwell.<sup>107</sup>

Another patient, Ann Howmann, passed through two different philanthropic institutions – the Chesham Alms Houses and the Norfolk Home – before her arrival at Hanwell. In both cases, she was expelled for 'quarrelling with the matron'. In neither instance was her quarrelsomeness taken as a sign of insanity.<sup>108</sup> Nevertheless, her exclusion underlines the desire for a certain level of discipline and order in charitable homes, which made them ill-suited venues for the care of the aged mentally infirm. Philanthropic and charitable institutions could offer material necessities, treatments for physical ailments, and a level of personal care, but they relied on the submission of a docile population, willing and able to

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<sup>105</sup> F. H. W Sheppard, *Survey Of London: Volume 37 - North Kensington* (1973); 'Little Sisters', *All the Year Round*, 33 (1884), pp. 156-59; Mangion, 'Faith, Philanthropy and the Aged Poor', pp. 515-30

<sup>106</sup> Mangion, 'Faith, Philanthropy and the Aged Poor', pp. 516-17.

<sup>107</sup> Agnes Ryder, Hanwell Casebook, Females No. 40, H11/HLL/B/19/063 (1912), p. 101.

<sup>108</sup> Ann Howmann, H11/HLL/B/19/037 (1892), p. 505.

receive this care without challenge. According to the observer from *All The Year Round*, St Joseph's provided care for the physically very needy, as well as the quietly demented. The letters regarding Agnes Ryder's case suggest that those who did not conform to this dependent role were considered unsuitable. By manifesting mental symptoms, Agnes had transcended her status as a member of the deserving, dependent aged poor. She was moved into a different institution, and, at the same time, transitioned into a different category of person: a lunatic.

Ann Howmann, the patient expelled from charitable institutions for 'quarrelling', was unusual. She had no known relatives, but she had her own, personal philanthropic benefactor. This was her former employer, Dr Charles Routh, who provided an extended, personally written account of Ann's life following her admission to Hanwell. Charles Routh was a successful hospital doctor, and president of the British Gynaecological Society.<sup>109</sup> Ann had worked under him as a 'surgical and medical nurse'. He was the person who had 'obtained her admission' to the Chesham Alms House and the Norfolk Home. When she was expelled, he did not allow her to go to the workhouse, but 'got somewhere for her and furnished her room for her'. Routh had continued to pay for Ann's upkeep, treat her physical disorders, and visit her frequently over a number of years. This was in spite of numerous 'quarrels', in which she shut him out of her rooms, refused to see him, and threatened violence towards him. He was moved to have her certified, he claimed, only once she threatened suicide.

How might we interpret and explain the lengths to which Dr Routh went to support Ann, prior to her institutionalisation? His actions may have been a continuation of his philanthropic activity, as a consulting physician to various charitable hospitals. There was certainly a paternalistic element to their relationship. Routh was keen to protect Ann's status as a 'respectable' working-class woman, making sure she stayed out of the workhouse, and describing her to Hanwell's medical officers as a 'very worthy, honest, and kindhearted soul'. Their relationship was characterised by attempts on his part to protect her from herself, to

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<sup>109</sup> *The Medical Directory for 1891*, (London, 1891), pp. 278-79.

control her environment, and to mitigate her tempers: at the hospital he 'never allowed her...to nurse a patient longer than 5 weeks', because of her quarrelsome nature. Routh's attitude towards Ann had the benevolent, but patronising air of a wealthy patriarch. He offered his aid and protection to her, at the same time as objectively noting her 'several faults': her 'ungovernable temper'; her tendency to be 'suspicious and doubting towards her friends'; her propensity for 'silly' quarrels. It therefore seems more accurate to describe their relationship as one of philanthropic patronage, than friendship. Yet Routh also expressed a sincere respect for Ann as 'an honest, painstaking Christian [and a] careful and skilled nurse, in whom I [have] the greatest confidence'. There are signs of genuine affection and concern in Routh's letter to the asylum: he wrote that he 'believ[es] her sufferings were terrible' and that 'it is a cause of great sadness to me that she has become disordered mentally'. Ann Howmann and Charles Routh's relationship was a non-familial one, underscored by the tensions of unequal gender and class positions, yet it was strong enough to endure 25 years of argument and upset. Routh's letter suggests that he was motivated by philanthropic obligation, but also by genuine respect, and even affection. Ann Howmann's case thus serves as a reminder that difficult older people, even those without a family, could find high levels of support outside the asylum.<sup>110</sup>

This relationship was, however, unusual. Over a third of the patients in this sample (excluding those who were transferred from another asylum), had no case-history narrative or letter included in their case notes. In some of these cases, a circular letter had been sent, but no response had been received. In others, the section of the case note for the 'friend's address' simply reads 'no relatives known'. Without these narratives, it is hard to tell what the lives of these isolated people were like, prior to their institutionalisation. The glimpses offered by the medical certificates, however, suggest quite horrifying neglect. As Pat Thane has noted, older people's negotiated independence can only go on 'until [dependency] became physically inescapable'.<sup>111</sup> Institutional records – particularly those of a medical

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<sup>110</sup> Ann Howmann, H11/HLL/B/19/037 (1892), p. 505.

<sup>111</sup> Thane, *Old Age in English History*, p. 123.

institution like the asylum – necessarily shine light on those whose experience of ageing was less positive: either due to the severity of their needs, or their isolation from social and economic resources. Rebecca Tully’s experience of confusion, filth and isolation, described at the start of this chapter, is the most unequivocal example of isolation and neglect in this sample. We cannot know how widespread experiences like Rebecca Tully’s were. However, her case serves as a stark reminder that we should not consider the more heartening stories contained in these case notes to be entirely representative. Whether due to social isolation, or the economic hardship of their surroundings, many of the older patients admitted to Hanwell had no discernable support network, and entered the asylum entirely alone.

### **Care and Management in the Home**

So far, this chapter has argued that Hanwell’s case notes reveal a prevailing sense of familial and community obligation, with regards to the care of their older, mentally disordered members. This obligation, however, was more keenly felt by some people than others, according to their gender, health, financial situation, and personality. Even for those willing to help, the types of support family and friends could offer were limited, beyond the material comforts of food and shelter, or simply offering money. There are a few examples in the case notes of medical help being solicited in the home. In only one of these cases is the form of medical care described in any detail. Henry William Parkes was subjected to leeching, blistering, mustard poultices and other medicines before he was admitted to Hanwell in 1852, these treatments having had little effect on his mental state.<sup>112</sup> When Jane Rose’s friends noticed that she was ‘strange’, the doctor was their first resort. Jane went to see a ‘medical man’ on their advice, and afterwards returned straight to her work as a domestic servant. Whatever treatment this doctor had offered, it apparently had little effect, and four days later the same friends had Jane removed to the infirmary.<sup>113</sup> Unsurprisingly, given that all of these patients eventually ended up in

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<sup>112</sup> Henry William Parkes, Hanwell Casebook, Males No. 2, H11/HLL/B/20/002 (1851), p. 300.

<sup>113</sup> Jane Rose, Hanwell Casebook, Females No. 19, H11/HLL/B/19/019 (1871), p. 333.

Hanwell, there are no reports in these case notes of successful medical treatment in the home. Instead, we are told, 'medical aid was resorted to without benefit'.<sup>114</sup>

Attempts to medically treat aged patients outside of the asylum were uncommon. Instead, most families concentrated on containing and managing their relatives' behaviour. Only two cases contain evidence of overt and explicit mechanical restraint taking place in the home: Thomas Alcock, admitted to Hanwell in 1852, was 'strapped down to his bed to prevent him from wandering about in a state of nudity' (leaving him with notable bruising on his legs), and Samuel Edmunds, admitted in 1891, was 'tied down' on account of his violence.<sup>115</sup> In other cases, there are references to surveillance and management which imply that physical coercion and restraint might have been resorted to, if necessary. Elizabeth Dyer's daughter, for example, explained that her mother had previously wandered out of the house and got lost, so that now she was 'afraid to leave her alone'.<sup>116</sup> John Dodge's wife told the doctor at Hanwell that 'he has had to be watched to prevent him from getting knives'.<sup>117</sup> Alternatively, these cases may represent examples of the 'domestic interpersonal psychiatric techniques' described by Akihito Suzuki. Suzuki argues that the key techniques for managing insanity within the home – among the elites at least – were centred on personal relationships and persuasion.<sup>118</sup> In the enforced intimacy of smaller, poorer living environments, such 'interpersonal' techniques were unlikely to have been neglected. John Auger's daughter explained that she had 'prevailed upon' him to dress, to wash, and to remain within the home, although she had not been successful.<sup>119</sup> In all of these examples, significant strain was placed on the carer, their lives dominated by constant watchfulness, frequent intervention and, sometimes, little success.

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<sup>114</sup> Richard Cullen, H11/HLL/B/20/011 (1871), p. 135; Henry Cook, H11/HLL/B/20/011 (1871), p. 287; Edward Brittan, H11/HLL/B/20/011 (1871), p. 27.

<sup>115</sup> Thomas Alcock, H11/HLL/B/20/002 (1852), p. 280; Samuel Edmunds, H11/HLL/B/20/021 (1891), p. 477.

<sup>116</sup> Elizabeth Dyer, H11/HLL/B/19/023 (1872), p. 5.

<sup>117</sup> John Dodge, H11/HLL/B/20/022 (1892), p. 47.

<sup>118</sup> Suzuki, *Madness at Home*, pp. 91-118.

<sup>119</sup> John Auger, H11/HLL/B/20/011 (1871), p. 71.



All of the caring relationships described above ultimately failed: in the end, all of these patients were removed from the home environment, and eventually went to Hanwell. Institutional displacement – in these cases, from the home to the workhouse – provided a relief to households and communities, when their attempts to manage a person's behaviour proved unworkable or unsustainable. In this way, the act of institutionalisation can be seen on a continuum with other acts of management, such as restraint or persuasion: it was the next step in the ongoing attempt to keep a person from harm, or to stop them from harming others (by disrupting their lives, if not physically hurting them). The medical certificates and case history narratives often point towards a 'tipping point': the event which put a fatal strain on previous arrangements, and thus precipitated the decision to take the step of institutionalisation.<sup>120</sup> These documents, then, give us some indication of the types of behaviour which constituted a breach of the boundary of tolerance.

If a person had exhibited symptoms of mental dissolution for some time, violent behaviour could be the trigger for institutionalisation. In February 1851, Dalby Scoone's daughter recounted his many years of 'extravagant' behaviour, writing reams of letters to men of rank including the King, at one point even going directly to Windsor to remonstrate with his Majesty in person. It was, however, when he became violent that 'it was necessary to send him from home'.<sup>121</sup> Henry Arnold's violence frightened his daughter, and she told the certifying doctor, 'He threatens to strike us. He is not safe at home'.<sup>122</sup> This statement carries a dual meaning: Henry Arnold's violence made him an unsafe person within the household, which in turn put his own safety in danger. His daughter both feared him and feared for him. Attempted or threatened suicide could also prompt institutionalisation. Dr Routh kept Ann Howmann in her own furnished rooms despite her violent and deluded behaviour, but sought certification when she asked if he would 'see her properly buried' after she ended her life.<sup>123</sup> When George

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<sup>120</sup> Nancy Tones, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883* (Cambridge, 1984), p. 109.

<sup>121</sup> Dalby Scoones, H11/HLL/B/20/2 (1851), p. 236.

<sup>122</sup> Henry Arnold, H11/HLL/B/20/21 (1891), p. 517.

<sup>123</sup> Ann Howmann, H11/HLL/B/19/037 (1892), p. 505.

Brown first showed signs of mental confusion, his daughter took him to live with her, during which time he apparently recovered quickly. When he later attempted to throw himself down a lift shaft, however, he was sent straight to the workhouse.<sup>124</sup> Suicidal people presented problems of management on practical and emotional levels. The doctor recording the case history narrative of John Dodge's wife, whose fear of her husband getting knives has been described above, noted that 'he has been a constant source of anxiety to his wife'.<sup>125</sup>

Other forms of disturbance, while less dramatic, could also be extremely disruptive. Harriet Staples' daughter sent her to the workhouse because she was 'very restless and noisy at night, so that it was impossible to have any rest'.<sup>126</sup> Lucy Ward was similarly reported to be 'very sullen at night, [and] had to be continually watched'.<sup>127</sup> As discussed above, Elizabeth Grey had been looked after in her son's home for five years, but when she began to 'wander in the streets', and had to be 'constantly watched' to keep her out of 'mischief', she was finally sent to the infirmary.<sup>128</sup> As well as these specific descriptions of disruptive behaviour, a general, unspecified unmanageability or troublesomeness was often cited as a reason to institutionalise someone. Benjamin Clark 'was sent to the workhouse being quite unmanageable at home', while Emma Casswell had previously become 'so excited and troublesome that it was found necessary to send her to [the asylum]'.<sup>129</sup> 'Unmanageable' and 'troublesome' are words which describe the effect of the individual on the people around them: they demand or refuse to *be managed*, they *cause trouble* to others. The frequent use of these terms underlines the fact that a patient's institutionalisation was determined by the limitations of environment from which they came, at least as much as the form and severity of their symptoms. It was, then, not so much the patient's behaviour itself, as the effect it had on others, which led to institutionalisation.

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<sup>124</sup> George Brown, H11/HLL/B/20/010 (1871), p. 239.

<sup>125</sup> John Dodge, H11/HLL/B/20/22 (1892), p. 47.

<sup>126</sup> Harriet Staples, H11/HLL/B/19/36 (1891), p. 154.

<sup>127</sup> Lucy Ward, Hanwell Casebook, Females No. 13, H11/HLL/B/19/036 (1891), p. 142.

<sup>128</sup> Elizabeth Grey, H11/HLL/B/19/038 (1892), p. 34.

<sup>129</sup> Benjamin Clark, H11/HLL/B/20/2 (1851), p. 74; Emma Sophia Casswell, H11/HLL/B/19/36 (1891), p. 172.

Families and friends who sought institutionalisation for their older charges, after a period of providing support for them in the home, had reached the limit of what they were willing and able to do for them. This was an event in which the emotional and the practical were intertwined. It was not simply a lack of financial resources, but a broader lack of practical resources, which prompted these families to relinquish the care of their older relatives. A violent loved one in particular presented immediate practical and emotional difficulties; their behaviour was both distressing and dangerous. Although less immediately dangerous, being kept awake at night by noise, or being tied to the obligation of watching a person who may wander out of the house or 'get into mischief', are experiences which are both physically and emotionally taxing. In this way, they also imperilled the material welfare of the home. According to the census, Harriet Staples' son, with whom she lived, was a boiler fitter, himself aged 51, and his ability to undertake this technical and physically demanding job were presumably significantly undermined by her keeping him awake at night.<sup>130</sup> The need for order or quiet in the home was a financial, physical and emotional need. Faced with an intolerable domestic situation, these families and friends had few options. For families and friends, the act of institutionalisation acted as a pressure-valve, displacing the management problems they faced onto another site of care and control. In most of these cases, the first institution the patient entered was a workhouse.

### **Order and the Workhouse**

The overwhelming majority of aged patients who arrived at Hanwell had passed through the workhouse, and it was from there that their certification was solicited and their admission to Hanwell secured. Families could choose to send their unmanageable aged relatives to the workhouse, but it was the people who managed and worked at London's workhouses and infirmaries – the Guardians, the masters, the medical officers, and the attendants – who were the key agents in the admission of aged patients to Hanwell. Thus, the capacity and willingness of the workhouse

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<sup>130</sup> Harriet Staples, H11/HLL/B/19/36 (1891), p. 154.

and its inhabitants to manage and tolerate senile residents can be considered the most important factor in determining the admission of aged patients to Hanwell.

The asylum records do not contain consistent information about how long their new patients had spent in the workhouse prior to admission. Some, it seems, had been there for several years, entering initially due to bodily infirmity or financial need, only to have their mental symptoms develop – or be noticed – some time after their arrival. Others were sent to the workhouse by their families – either directly or through the Relieving Officer – on account of their mental symptoms, and were swiftly certified and sent on to Hanwell in a matter of days. The practice of using the workhouse as a ‘holding area’, or ‘filtering stage’ in the road to the asylum took place across the country, and was particularly common in London.<sup>131</sup> Elaine Murphy, in her study of the East London Poor Law Unions in the mid-nineteenth century, found that the workhouse constituted ‘the first point of admission’ for insane paupers, who were brought to the workhouse by the Receiving Officer to be assessed *in situ*, and often remained there for some weeks to see if they would recover.<sup>132</sup> This practice became even more important in 1889, when the management of Hanwell and the other county asylums in the new administrative county of London was taken over by the LCC. From this point on, any London Poor Law Union seeking asylum admission for one of its paupers had to apply centrally to the LCC, and await a decision as to where they would be placed. This did not, however, alter the balance of power in controlling which patients were admitted to the asylum. Even after 1889, the LCC was obliged to find space in their county asylums for any patient who had been certified as a lunatic in needs of detainment in the asylum.<sup>133</sup> Beyond communicating their displeasure to the Lunacy Commissioners, the Local Government Board and to the individual boards of Guardians, there was essentially nothing the Hanwell management

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<sup>131</sup> Richard Adair, Bill Forsythe and Joseph Melling, ‘A Danger to the Public? Disposing of Pauper Lunatics in Late-Victorian and Edwardian England: Plympton St Mary Union and the Devon County Asylum, 1867-1914’, *Medical History* 42 (1998), p. 155.

<sup>132</sup> Murphy, ‘The Lunacy Commissioners and the East London Guardians, 1845-1867’, p. 513.

<sup>133</sup> *The Fourteenth Annual Report of the [LCC] Asylums Committee* (1902-3), p. 6. See also *The Thirty-Second Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1877), pp. 6-7.

committee could do to prevent the arrival of aged patients. As discussed in the previous chapter, this was a cause of significant tension between the asylum and London's Poor Law Guardians.

More broadly speaking, money was at the heart of the tensions between the Poor Law and the asylum. For the first thirty years of their existence, the Lunacy Commissioners railed against Poor Law Guardians for retaining lunatics in the workhouse, where they could be supported much more cheaply, rather than sending them to the asylum where they could be cured. After the introduction of the four-shilling grant in 1874, they began to accuse workhouse officials of being *too* eager to send slightly disruptive and difficult inmates to the asylum. Even after the introduction of the four-shilling grant, however, it generally remained cheaper for lunatics to be maintained in the workhouse. Joseph Melling and Bill Forsythe, for example, in their study of the administration of lunacy in Devon, have suggested that 'the comparative high cost of asylum care would have led to a reluctance among asylum personnel to send paupers on to Exminster [asylum]', all the way up to the early years of the twentieth century.<sup>134</sup> In London, however, the situation was rather different. In 1867, the Metropolitan Poor Act introduced the Common Poor Fund, designed to equalise the burden of paying for sick paupers between the unequally wealthy London Poor Law Unions. This central fund paid for, among other things, the maintenance of London's pauper lunatics in county asylums. This put London Poor Law Unions – particularly the poorer ones – in a very different financial position with relation to lunacy than those in the rest of the country.<sup>135</sup> Furthermore, historian David Cochrane has argued that the differentiation between the cost of maintaining a pauper lunatic in a workhouse and an asylum was 'flattened' by the universally high cost of pauper maintenance in London in the last three decades of the nineteenth century. It was not that it was particularly cheap for a pauper to be maintained in a London asylum, but rather that it was almost as

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<sup>134</sup> Joseph Melling and Bill Forsythe, *The Politics of Madness: the State, Insanity and Society in England, 1845-1914* (London, 2006), p. 36.

<sup>135</sup> Murphy, 'The Lunacy Commissioners and the East London Guardians, 1845-1867', pp. 519-21; David R. Green, *Pauper Capital: London and the Poor Law, 1790-1870* (Farnham, 2010), pp. 238-39.

expensive for them to be maintained in the workhouse.<sup>136</sup> There was, then, no real financial incentive nor disincentive for London Poor Law Guardians to send more or fewer of their paupers to an asylum, or to maintain lunatics in the workhouse.

Instead, the evidence from the admissions records of Hanwell supports Peter Bartlett's argument that it was 'the problem of order' which ultimately determined the movement of an individual from a workhouse to an asylum.<sup>137</sup> Order and the 'power of rule' were central to the rhetoric of efficiency in which the institutions and policies of the New Poor Law were produced. Under the New Poor Law, the workhouse was framed as a site of moral regulation, in which orderly and productive behaviour was to be encouraged. Peter Bartlett, and workhouse historian Felix Driver, have interpreted this drive for order through Michel Foucault's concept of 'disciplinary power'.<sup>138</sup> This can be described as system for organising institutional regimes, in which individual behaviour is monitored and prescribed to a minute degree, in an attempt to normalise that behaviour, and create productive social actors.<sup>139</sup> Thus, Emma Sophia Casswell was removed from the Hampstead workhouse in part because she '[would] not conform to the rules of this institution'.<sup>140</sup> At the same time, Driver recognises the insufficiency of Foucault's model to account for the multiplicity of roles performed by the Victorian workhouse, as spaces of confinement and care as well as moral regulation.<sup>141</sup> Whilst a useful starting point for thinking about the desire to manage and control activity within the workhouse, this model does not quite account for the problems caused by senile patients. Disciplinary power is, as Foucault describes it, directed at actions performed by a necessarily *active* body, seeking to make the individual more

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<sup>136</sup> David Cochrane, 'Humane, Economical and Medically Wise': the LCC as Administrators of Victorian Lunacy Policy', in William F. Bynum and Roy Porter (eds), *The Anatomy of Madness: Essays in the History of Psychiatry*, Vol. III (London, 1988), pp. 249-52.

<sup>137</sup> Bartlett, *The Poor Law of Lunacy*, pp. 179-82.

<sup>138</sup> Felix Driver, *Power and Pauperism: the Workhouse System, 1834-1884* (Cambridge, 1993), p. 11.

<sup>139</sup> Michel Foucault, *Discipline and Punish: the Birth of the Prison* (New York, 1977), p. 139.

<sup>140</sup> Emma Sophia Casswell, H11/HLL/B/19/036 (1891), p.172.

<sup>141</sup> Driver offers a summary of these in Driver, *Power and Pauperism*, pp. 10-15.

efficient, more economic, and more controlled.<sup>142</sup> What was desired of these aged patients was not efficient activity, but *inactivity*.

The desire for inactivity is communicated through the frequent reference to 'restlessness' in the medical certificates and the case history narratives. The term 'restlessness' adds depth to the idea of unmanageability: it suggests a constant movement and activity that is neither desired nor controllable. What is desired of the restless person is that they rest. Thus, senile patients disrupted the order of the workhouse by failing to perform the role of docile dependents. Several of the medical certificates in this sample mention the trouble caused by aged patients who refused to stay in bed. The head nurse at the Paddington Infirmary complained that she 'had great difficulty keeping [Mary] in bed, by night or day'.<sup>143</sup> John Auger, who entered the workhouse apparently for the first time at the age of 79, 'walked about the ward, rattled and knocked at doors [and] asked why he should go to bed'.<sup>144</sup> Martin Bates 'cut the head [of a workhouse nurse] open in two places [who was] endeavouring to make him comfortable in his bed'.<sup>145</sup> These patients not only presented the challenge of needing to be looked after, but resisted the attempts of those around them to meet this challenge.

This information, like much of the evidence of insanity included in the medical certificates of Hanwell's aged admissions, was provided by nurses and attendants of the workhouse. Henry Rayner, Superintendent of Hanwell in the 1870s and 80s, was sceptical of such statements. In his annual report of 1877, he wrote that he was

frequently at a loss to recognise in the helpless, childish, bed-ridden and often moribund old man, the dangerous and violent lunatic described in the certificate under the head of "Facts

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<sup>142</sup> Foucault, *Discipline and Punish: the Birth of the Prison*, p. 139.

<sup>143</sup> Mary Carter, H11/HLL/B/19/23 (1872), p. 69.

<sup>144</sup> John Auger, H11/HLL/B/20/011 (1871), p. 71.

<sup>145</sup> Martin Bates, Hanwell Casebook, Males No. 12, H11/HLL/B/20/012 (1872), p. 167.

Indicating Insanity", communicated to the medical man, usually by the nurse or attendant on the patient.<sup>146</sup>

This was a blatant accusation of deceit on the part of the workhouse attendants who, he claimed, exaggerated the violent tendencies of their charges in order to secure their admission to the asylum. Henry Rayner's assessment, however, is not borne out by the evidence in Hanwell's own case books. The medical certificates examined in this study offer few examples of violent and dangerous acts. Far more common were descriptions of comparatively minor, but no less troublesome, acts of disturbance. The nurse of St George's workhouse informed the certifying doctor that Ann Allcock 'scream[ed] and shout[ed] often at night for hours at a time, disturbing everybody in the house at a long distance from the ward.'<sup>147</sup> Rebecca Brookman '[did] not allow[] any of the inmates of the ward to sleep with her continual vociferations'.<sup>148</sup> Other patients physically spread their disruption about the ward by 'interfering' with other patients. Ann Foley 'constantly undressed herself [and] wander[ed] about the house and premises, [got] out of bed at night, pull[ed] the clothes off other beds and frighten[ed] the people'. George Connigton took this one step further, 'throw[ing] off his bedclothes' and 'get[ting] into other patients beds'. These were uncontained people, whose disruption and disorder leaked beyond the boundaries of their own person and rendered the people around them as disturbed as they were. If their symptoms could not be contained within their person, or within a more appropriate time of day, then they were sent to have their symptoms contained within the walls of the asylum.

## Conclusion

In Chapter Two, it was suggested that the administrators of lunacy significantly misjudged the role of the asylum, when they complained about the certification of 'senile' patients. In their annual reports the Lunacy Commissioners argued that such patients did not belong in the asylum, because they were 'manageable' and

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<sup>146</sup> *The Thirty-Second Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1877), p. 39.

<sup>147</sup> Ann Allcock, H11/HLL/B/19/022 (1872), p. 215.

<sup>148</sup> Rebecca Brookman, H11/HLL/B/19/36 (1891), p. 322.



because their infirmities were 'natural'. This chapter has suggested that the former claim – that old asylum admissions were easy to manage – was manifestly untrue, and that the latter claim – that senile patients were not insane – was irrelevant. The admissions process should not be seen as 'two separate decisions, first whether the individual was insane, and, second, what was to be done with him or her. They were co-mingled and indisitinguishable issues'.<sup>149</sup> Asylum admission was a response to a problem of (dis)order, which had subjectifying effects: it legally transformed the unmanageable person into a lunatic. Thus, the structures of welfare which operated in nineteenth-century London, in which asylum admission was one of the few available solutions to the problem of unmanageable people, rendered the division between 'insanity' and 'senility' meaningless. People were sent to Hanwell because they had exhausted the financial, practical or emotional resources available to those outside the asylum – in the family, the wider community, and the workhouse – to manage and contain their behaviour. This was as true for people in their 60s, 70s and 80s, as it was for younger people.

In terms of entry to the asylum, then, there was little distinction to be made between older and younger patients. Within the walls of the asylum, however, this distinction was being made with increasing frequency and clarity towards the end of the nineteenth century. The determination to distinguish 'senile' asylum patients from others in the political rhetoric of lunacy made little difference in determining who arrived at the asylum. But this dividing imperative *was* reflected in (and engendered by) the classificatory practices which took place after admission. The next chapter will consider the effects of this: the emergence, in the asylum records, of the 'senile' patient.

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<sup>149</sup> Bartlett, *The Poor Law of Lunacy*, p. 182.

## Chapter Four: The Emergence of the Senile Patient at Hanwell

In 1851, the word 'senile' rarely appeared in the patient records of Hanwell asylum. By 1912, it was commonplace. This chapter seeks to account for this significant change. It argues that this mutation in nomenclature reflected a broader shift in the way that mental disorders in old age were classified and understood. At the beginning of this period, the insanity of older patients was placed within a broad psychiatric framework, in which age was a marginally important factor. By the beginning of the twentieth century, aged patients were more likely to be viewed *as* old, and the distinctive agedness of their bodies became a prominent factor in the way that their insanity was classified and, by extension, understood.

This thesis has already examined this change in different areas of psychiatric discourse and practice. Chapter Two charted the increasing frequency with which 'senile' patients were mentioned in the administrative discourse of lunacy at the end of the nineteenth century. It showed that the increased commentary on the senile was underpinned by a desire to exclude unpromising patients from the asylum, and thus went hand-in-hand with an attempt to differentiate the senile from the rest of the asylum population. This rendered them a 'problem' category, rather than an inherent part of the behaviourally disordered population whose institutional journeys often led to the asylum (as discussed in the Chapter Three). Thus, the senile patient was defined by the criteria which legitimated their exclusion from the asylum: as physically feeble, essentially manageable, and inherently and irreversibly aged. Chapter One similarly argued that the inherent agedness of old-age insanity also became increasingly important in theoretical psychiatric texts, as psychiatrists sought a somatic basis for psychiatric categories.

This chapter brings these two strands of argument together, through an examination of Hanwell's patient records. It argues that this period saw the emergence of a decisively differentiated 'senile patient' in the asylum records – particularly the case books – identified by their physical characteristics, the form of their insanity, and the cause assigned to it. It suggests that the mutating structure of the records themselves was central to bringing about these changes in

understanding. The changing administrative and medical priorities and interests described in the first two chapters of this thesis were reflected in, and reinforced by, the changing format of asylum patient records. Thus, this chapter argues that changing record-keeping practices played an important part in bringing the 'senile patient' into being. Over this period, insanity *in* old age became, to a far greater extent than before, insanity *of* old age; a development both reflected in, and constructed through, the changing tools of medical and administrative practice.

### *The Aged Subject*

This argument – that a 'senile patient' emerged in the latter part of the nineteenth century – echoes a broader observation, made by Karen Chase and Stephen Katz, that the nineteenth century saw the emergence of an 'elderly subject' or an 'aged subject'.<sup>1</sup> The Victorians did not discover old age, but certain social, institutional and cultural changes in this period shaped ideas about old people into a clearly defined, recognisable subject: an entity about which general truths could be known, and which could be acted upon in particular ways. This aged subject, argue historians such as Katz and Andrew Achenbaum, had particular physical and physiological features - 'a special type of body with its own signs and fixed lifespan, a body whose senescent ills and internal dying required specific senile therapeutics' - and occupied a particular social position, one of dependence and economic marginalisation.<sup>2</sup> It was, then, through the twin disciplines of medicine and social research or policy, that the aged subject most decisively emerged. Over the course of the nineteenth century, old people became more visible to these disciplines in a number of ways. The gathering of older people into the large institutions of the infirmary, workhouse and asylum, brought them to the attention of policy makers. When these institutions also contained doctors, it also brought

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<sup>1</sup> Karen Chase, *The Victorians and old age* (Oxford, 2009), p. 102; Stephen Katz, *Disciplining Old Age: the Formation of Gerontological Knowledge* (Charlottesville, 1996), pp. 45-48. Without explicitly referring to an aged 'subject', other historians of old age have similarly argued that the nineteenth century saw a political, medical and cultural recognition that the aged constituted 'a clearly defined subset of the population': Susannah R Ottaway, *The Decline of Life: Old Age in Eighteenth-Century England* (Cambridge, 2004), pp. 10-13; Kay Heath, *Aging By the Book: the Emergence of Midlife in Victorian Britain* (Albany, 2009), pp. 3-5; W. Andrew Achenbaum, *Old Age in the New Land: the American Experience since 1790* (Baltimore, 1978), pp. 34-37.

<sup>2</sup> Katz, *Disciplining Old Age*, pp. 45-46; Achenbaum, *Old Age in the New Land*, pp. 48-51.

them to the attention of the medical gaze. The accumulation of old people in the enormous *hopitaux generales* of Paris, for example, stimulated the burst of medical research into old age which appeared in mid-nineteenth century France.<sup>3</sup> At the same time, the new science of pathological anatomy, also flourishing in Paris, made the aged body visible in a different way: it brought to light the internal signs of physiological senescence.<sup>4</sup> Through observing the structures of the aged body, researchers in Paris 'formulated a definition of old age that separated it medically from other groups and demanded doctors' complete attention'.<sup>5</sup>

Institutionalisation was not the only phenomenon through which older people became more visible. When Charles Booth went out into the streets of London to conduct his social surveys, designed to explore the problem of poverty, he was unexpectedly confronted by large numbers of impoverished old people. This led him to the startling conclusion that 'on the whole, people are poor because they are old', and to turn his attentions to the welfare of the aged poor specifically, and begin to campaign for old-age pensions.<sup>6</sup> The turn of the century, then, saw the aged subject move from an object of knowledge to a target of social policy.

Individual scholars have identified other factors to account for the increasing prominence of old age in late-nineteenth-century cultural discourses: Karen Chase describes the conspicuous visibility of the ageing Queen Victoria, while Thomas Cole points to the importance of old age to the Victorian cult of self-improvement, both as a condition to be ameliorated and as a measure of success.<sup>7</sup>

The emergence of the senile subject in the asylum records did not take place in isolation from these broader developments. The asylum was one of those

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<sup>3</sup> Katz, *Disciplining Old Age*, p. 46; Peter N. Stearns, *Old Age in European Society: the Case of France* (London, 1977), pp. 84-85; Carole Haber, *Beyond Sixty-Five: the Dilemma of Old Age in America's Past* (Cambridge, 1983), pp. 58-59.

<sup>4</sup> Haber, *Beyond Sixty-Five*, pp. 58-62. See Ackerknecht *Medicine at the Paris Hospital* for the classic account of 'Paris medicine'.

<sup>5</sup> Carole Haber, 'Geriatrics', in David D. Van Tassel and Peter N. Stearns (eds), *Old age in a Bureaucratic Society: the Elderly, the Experts, and the State in American History* (Westport, 1986), p. 70.

<sup>6</sup> Pat Thane, *Old Age in English History: Past Experiences, Present Issues* (Oxford, 2000), pp 173-77; Chase, *The Victorians and Old Age*, pp. 242-46; Charles Booth, *The Aged Poor in England and Wales* (London, 1895), p. 54.

<sup>7</sup> Chase, *The Victorians and Old Age*; pp. 153-68; Thomas R. Cole, *The Journey of Life: a Cultural History of Aging in America* (Cambridge, 1992), pp. 139-58.

institutions in which the aged accumulated: according to officially published statistics, the proportion of Hanwell's resident inmates who were aged 60 or over rose from 15 per cent in 1850 to 28 per cent in 1900. There was also a notable increase in the proportion of patients who, at the time of admission, were aged 60 or over.<sup>8</sup> While important, the ageing of the asylum population does not in itself account for the increasing prominence of 'senility' in the patient records. There were other factors which contributed to the visibility of old age in the asylum and which, as Roy Porter puts it, 'magnifie[d] its growing reality'.<sup>9</sup> As Nicholas Rose has argued, institutional confinement renders a large group of people visible within 'a single common plane of sight', which allows the individuals to be observed as 'entities both similar and different from one another'.<sup>10</sup> The observational and classificatory practices of the asylum, therefore, played a central role in constructing senility in the asylum, foregrounding certain features that in turn shaped the way that the patient population was differentiated. In particular, the increasing prominence of the body in both the theory and practice of psychiatry during this period underwrote this institutional differentiation. Just as the rise of pathological anatomy in mid-century Paris influenced the conceptualisation of old age in physiology and medicine, the increased focus on the body in psychiatry changed the conceptualisation of insanity in old age. The practice of close investigation of the body led to an increased awareness and interest in the physical signs of senescence. This was expressed in Hanwell's case notes through the creation of a new category of bodily condition: 'senile'.

This chapter seeks particularly to examine the importance of changing record-keeping practices, and the changing epistemological values they reflected and engendered. 'Inscribing and recording' was an important part of the 'disciplining of difference' in all large institutions.<sup>11</sup> This point has been emphasised by Catharine Coleborne, who highlights the importance of asylum case

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<sup>8</sup> See Figure 5, p. 116.

<sup>9</sup> Roy Porter, 'Dementia: Social Section - Part I', in G. E. Berrios and Roy Porter (ed.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London, 1995), p. 56.

<sup>10</sup> Nikolas Rose, 'Calculable Minds and Manageable Individuals', *History of the Human Sciences*, 1 (1988) p. 187.

<sup>11</sup> Rose, 'Calculable Minds and Manageable Individuals', p. 187.

notes in 'the process of inventing patients', and particularly in bringing to light the 'difference' – in terms of gender, race and age – of various patient groups.<sup>12</sup> The options given to clinicians, in terms of the volume and type of information they record, shape what is (or can be) known about the patient. Shifting emphases in the medical record – for example, the increasing space given over to specific physical signs and symptoms – both reflect and engender shifting emphases in medical knowledge. Different types of medical record, centring on different types of knowledge, thus 'produce' different types of body; categorised, imagined and understood in different ways.<sup>13</sup> The medical record also 'plays an active, constituent role in... medical work'.<sup>14</sup> Though not determining it, the record structures the medical encounter and directs the methods and targets of observation and examination. For example, a space for 'pulse' on the case books form, first introduced on the female side of the asylum in the late 1880s, directed the assistant medical officers to take that particular measurement in the course of their medical examinations.

At Hanwell, the changing structure of the case note also dictated medical officers' encounters with patients' friends and family members. As the way in which lay narratives were recorded became increasingly prescriptive, the role of these outside informants changed: from narrators of a patient's subjectivity, to holders of discrete, objective information which could be brought to bear on the medical assessment. This in turn reinforced the objectification of patients, and the importance of observable, often physical, signs in the classification of mental disorders. As patients' biographies became less important, and patients' bodies became more so, the aged body often replaced late-life experience as the primary explanatory factor in the mental disorders of older people.

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<sup>12</sup> Catharine Coleborne, 'Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, c. 1880–1910', *Social History of Medicine*, 19 (2006), pp. 11, 62, 165.

<sup>13</sup> Marc Berg and Geoffrey Bowker, 'The Multiple Bodies of the Medical Record: Toward a Sociology of an Artifact', *The Sociological Quarterly*, 38 (1997), pp. 514–15.

<sup>14</sup> Marc Berg, 'Practices of Reading and Writing: the Constitutive Role of the Patient Record in Medical Work', *Sociology of Health & Illness*, 18 (1996), p. 501.

This chapter will proceed with an overall summary of the changes in the form of Hanwell's patient records between 1851 and 1912. It will then examine three different elements of the case note in turn – the form of insanity, the physical condition, and the cause of insanity – which were subject to these changes. In each of these elements of the case note, there was an increasing tendency, in the latter part of the nineteenth century, to describe aged patients as senile. Through these changing records, we can both witness and account for the emergence of the senile patient.

### **The Structure of the Patient Records<sup>15</sup>**

Between 1851 and 1911, the structure of Hanwell's case books changed dramatically. The average number of pages dedicated to each patient rose from one to four, and the pages themselves doubled in size. The case book format became increasingly standardised and prescribed, and the information to be recorded about the patient became more detailed and disaggregated. Long, open narratives were replaced with dense, pre-printed forms requiring short, discrete answers. Thus, Hanwell's patient records demonstrate one of the central tendencies in modern medicine observed by Foucault in *Birth of the Clinic*: 'a new "carving up" of things'.<sup>16</sup> The move towards standardisation and prescription is a common feature of hospital records during the late-nineteenth and early-twentieth centuries.<sup>17</sup> Developments at Hanwell, then, were part of a much broader change in medico-institutional practices which took place over this period.

Record-keeping practices at Hanwell were shaped by medical, legal and administrative requirements. The 1845 Lunacy Act dictated that all asylums keep two types of patient record: an 'Admissions Book' and a 'Case Book'.<sup>18</sup> The format for the admissions book was prescribed in this legislation, and did not change

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<sup>15</sup> See Appendix 2 for illustrations of the changing case book formats.

<sup>16</sup> Michel Foucault, *The Birth of the Clinic: an Archaeology of Medical Perception* (London, 2003), p. xx.

<sup>17</sup> Barbara Lazenby Craig, 'Hospital Records and Record-Keeping, c. 1850-c. 1950, Part I: The Development of Records in Hospitals', *Archivaria*, 29 (1989), pp. 61-62; Joel D. Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore, 1996), pp. 45-47.

<sup>18</sup> *The Lunacy Act* (1845), s. 50, 60.

substantially until the early twentieth century. The admissions book was essentially a list of patients, in the order they were admitted, along with columns for key information. This included social, demographic and financial information – such as age, marital status, and the chargeable union – and medical information – such as the form, cause and duration of insanity. The case book, initially, was a more fluid document. It was originally designed to contain an ongoing description of each patient's mental state and bodily health, and to record any treatments applied by the medical officers. In 1851-52, the last years of John Conolly's employment at Hanwell, case book entries were made on blank pages, and consisted mostly of open description. The case note entries for each patient were minimal, usually contained within a single page. Each entry included the patient's name, a short summary of their mental state on admission, and an account of their history as given by a friend or relative. There were often no further entries, other than a final one recording the date of discharge or death. The case notes at this time were dominated by the case history: the narrative of the patient's condition and experiences prior to their institutionalisation took up by far the most space. Lay knowledge – the knowledge held by those who had observed the patient prior to their presentation before the medical gaze – was thus central to the conceptualisation of the patient. The progressive marginalisation of these lay narratives over the following 50 years is, this chapter will argue, central to the emergence of the 'senile patient', whose mental state was attributed to their physical state, rather than their life experiences.

After Conolly left Hanwell, the superintendence of the asylum was split in two: the male and female sides of the asylum each had their own Medical Superintendent, operating largely independently of each other. The significant difference in the format of the case books on the male and female sides of the asylum in the 1870s demonstrates the significant autonomy of individual Superintendents over record-keeping in this period.<sup>19</sup> On the male side, much of

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<sup>19</sup> Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11 (1998), p. 261.



the pertinent medical information which might have been included in the case book was siphoned off into a separate volume, the 'Clinical Journal' (which, unlike most of Hanwell's records, has not survived), while the female side retained a single case book. Entries in the male case books of 1871-72 differ little from those produced 20 years earlier. The female case books, on the other hand, are far more comprehensive. The entries were still recorded onto blank pages, but the apparent openness of these unprinted pages is somewhat misleading. Conventions as to the type and location of information recorded, added a significant level of regularity to the female case books. There was no printed form for the recording of demographic information into the case book at this time, but there may as well have been: attributes such as gender, age, marital status, occupation, religion, and address, were listed in a regular order, at the top of every case note. Women's case notes always went over at least two pages, with the right-hand page dedicated exclusively to information gleaned from the testimony of their friends or relatives. In the 1860s, on the female side of the asylum, the practice of copying the patients' medical certificate into the case book first began. Thus, moves towards standardisation in record-keeping were beginning prior to the introduction of printed case book forms.

Between 1872 and 1891, a number of changes occurred in the format of Hanwell's patient records. The blank pages of the case books were replaced with printed forms, which prescribed and directed the behaviour of the medical officers in a much more obvious and codified way. The forms adopted in the case books on the male and female sides were still somewhat different, with a greater level of prescription adopted on the female side. In both the male and female case books, the new forms gave space for a much longer and more detailed description of the patient's physical state than had usually been provided in the more open case-book format. As far as the patient case histories were concerned, the 1891-92 case books still provided a large space for open narrative but, on the female side, there was now also a prescribed list of information to be elicited from the narrator. The case books of the 1890s, then, directed the behaviour of the medical officers more than

ever before, and dictated more directly the manner of the interaction between the medical officer and the lay narrator.

In the early years of the twentieth century, Hanwell's patient records were subject to interventions from both the Lunacy Commissioners and the London County Council (LCC) who, after the 1889, managed Hanwell through the central LCC Asylums' Committee. In 1907, the LCC introduced a standardised case book, to be used in every LCC asylum. This case book was even more prescriptive than the 1891-92 case books, and the space for open narrative was significantly reduced. The space devoted to the patient's physical condition now took up almost an entire page (even though the pages themselves had also increased in size). With the introduction of this standard, the LCC took on the authority of directing the medical officers' observations towards certain physical characteristics, and of deciding which pertinent information should be elicited from their friends and relatives. At the same time, they took the further step of directing where – not just how – the case books should be completed. They issued a directive, along with the new case books, stating 'that case-notes [should] be made on the ward on a case-paper, in the presence of the patient, and that the provisions for the statutory case-book be copied from the case papers'.<sup>20</sup> The case books of 1911-12 thus constitute a tamed version of the potentially more chaotic and idiosyncratic original case notes. To cope with the increased clerical load, Superintendent Percy Bailey hired a 'lady clerk', named Maud Forbes, to complete the transcription of the case notes into the case book.<sup>21</sup> This intervention added a further layer of uniformity to the case books: the printed forms (with the exception of the sections elicited from the testimony of friends and families, which continued to be completed by the medical officers) were all completed in Maud Forbes' neat, consistent hand.

The LCC interventions into the asylum patient records of the early twentieth century only concerned the case book. In the same period, the Lunacy Commissioners brought about substantial changes to the format of the admissions

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<sup>20</sup> *The Eighteenth Annual Report of the [LCC] Asylums Committee* (1907), p. 24.

<sup>21</sup> *The Nineteenth Annual Report of the [LCC] Asylums Committee* (1908), p. 66.

registers. The original admissions book, whose format had remained essentially the same since the 1840s, was a place where key demographic, biographical and medical information about each patient was collected together in one place. In the 1890s, the Commissioners began to differentiate between these types of knowledge. In 1890, they issued a set of 'Rules', which included a stipulation that the 'form of insanity' should be completed by a medical officer, while the rest of the information could be completed by a clerk.<sup>22</sup> In 1906, the Lunacy Commissioners extended this division of labour and knowledge, by replacing the admissions book with two separate admissions registers: the 'Civil Register' and the 'Medical Journal'. The civil register, they ordered, was to be completed by the clerk of the asylum immediately after a patient's arrival. It contained only information pertaining to their social, demographic and financial status, asking for marital status, previous address and chargeability. Information on the type, aetiology and duration of their mental condition was diverted to the dedicated medical journal, which the medical officer had three months to complete.<sup>23</sup> This change itself suggests there was a new way of seeing the patient, echoing the marginalisation of the case history in the case books. By splitting the civil and medical registers, the social aspect of a patient's life was displaced and divided from the medical understanding of their condition.

The medical journal, it seems, was designed to facilitate large-scale, remote statistical analysis. In order to further facilitate this statistical analysis, schedules of approved 'forms of insanity' and 'causes of insanity' were issued.<sup>24</sup> Each of these forms and causes was assigned a code. In order to complete these statutory records, asylum medical officers had to assign to their patients a form and cause of insanity which was included in this prescribed list. Consequently, the medical journal brought a new level of standardisation and restriction to asylum classificatory practices, and shifted authority over clinical decisions away from medical officers

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<sup>22</sup> 'Rules made by the Commissioners in Lunacy with the Approval of the Lord Chancellor, 25 March 1890', reprinted in James William Greig, William H. Gattie and John Frederick Archbold, *Archbold's Lunacy and Mental Deficiency* (5th edn, London, 1915), pp. 407-8.

<sup>23</sup> 'Rules made by the Commissioners in Lunacy, 31 October 1906', reprinted in Greig, Gattie and Archbold, *Archbold's Lunacy and Mental Deficiency*, pp. 556-57.

<sup>24</sup> Copies of these codes are hard to find, but some can be viewed at The Bothwick Institute for Archives, NHS/P12, with thanks to archivist Katherine Webb for providing this reference.

and towards the central bureaucracy. Unlike the other forms of standardisation described above, the medical journal did more than just direct asylum medical officers towards certain aspects of a patient's disorder, and ensure that sufficient information about the patient was being collected and recorded. The prescribed classificatory schedules flattened the significant disagreements between practising psychiatrists over the classification of insanity, and enforced a particular set of epistemological values. The 1907 schedules prescribed a national understanding of insanity.

The three types of change described here – increased levels of standardisation and prescription, the breaking up of long narratives into disaggregated forms, and the marginalisation of biographical information in favour of physical description – all had a significant impact on the way that older patients at Hanwell were viewed and categorised. The rest of this chapter will argue that these changes both reflected and engendered new priorities in the categorisation and description of Hanwell's patients. These new priorities brought the agedness of old patients to the fore, at the expense of other potentially pertinent aspects of their condition.

### **The Form of Insanity**

Every patient who arrived at Hanwell was given a diagnostic label – called the 'form of insanity' – which was recorded into both the admissions book (latterly the medical journal) and, from the 1870s onwards, the case book. It is unclear who precisely assigned these diagnostic labels, and at what point. However, the changing patterns of diagnosis, reflected in the annual reports, indicate that the Medical Superintendents directed the classificatory scheme in use under their authority, and that they probably assigned these diagnostic labels themselves. An analysis of the forms of insanity assigned to patients aged 60 or over clearly demonstrates the increasing tendency to relate older patients' mental disorders to their aged condition. In the latter part of the nineteenth century, the proportion of

these patients who were assigned a 'senile' diagnostic label increased substantially, as shown in Table 1.<sup>25</sup>

| Form of insanity on admission                        | 1851-2 | 1871-2 | 1891-2 | 1911-2 |
|--|--------|--------|--------|--------|
| Senile insanity                                      | 4      | 0      | 0      | 0      |
| Senile mania   | 0      | 10     | 6      | 1      |
| Senile melancholia                                   | 0      | 2      | 12     | 2      |
| Senile dementia                                      | 0      | 8      | 34     | 36     |
| Senile dementia with paralysis                       | 0      | 1      | 5      | 0      |
| Other 'senile' diagnosis                             | 1      | 1      | 4      | 0      |
| Total patients given 'senile' diagnosis              | 5      | 22     | 61     | 39     |
| Total patients aged 60 and over admitted             | 31     | 122    | 123    | 105    |
| % patients aged 60 and over given 'senile' diagnosis | 16     | 18     | 50     | 37     |

Table 1. Senile forms of insanity in patients aged 60 or over on admission to Hanwell, 1851-1912

Between 1871 and 1891, the number of patients aged 60 and over on admission who were given a 'senile' diagnosis almost tripled, rising from 22 to 61. This increase cannot be accounted for by an increase in aged admissions. Although there was an overall increase in the second half of the nineteenth century in the proportion of Hanwell's admissions aged 60 or over, the opening of Caterham and Leavesden led to a temporary drop in aged admissions during the 1870s and 1880s. The number of patients admitted who were aged 60 and over was almost identical in 1871-72 and 1891-92. However, as Table 1 shows, the percentage of patients aged 60 and over who were given a 'senile' diagnosis went up from 18 per cent in 1871-72 to 50 per cent in 1891-92. The same pattern can be discerned if the sample is restricted to patients aged 70 or over: 30 per cent of patients in this group were

<sup>25</sup> Any form of insanity with the word senile prefixed (eg. 'senile dementia') or suffixed (eg. dementia senile) to it, including those with 'senile' written in brackets (eg. mania (senile)).

labelled senile in 1871-72, rising to 77 per cent in 1891-92. At the end of the nineteenth century, then, older patients were far more commonly given a senile diagnosis than they were in the mid-nineteenth century. This tendency decreased somewhat in the early twentieth century, although the proportion of over-sixties given a senile diagnosis remained significantly higher than it had been in the 1850s and 1870s.<sup>26</sup> Thus, Table 1 indicates that, at the end of the nineteenth century, Hanwell's Superintendents became more likely to characterise aged patients as 'senile' than before, a tendency which is borne out in other areas of the case note.

Table 1 also indicates a change in the range of senile diagnoses being used. 'Senile insanity', the term used in the 1850s, had entirely disappeared by the 1870s. In the 1870s and 1890s, a range of senile diagnoses were being used at Hanwell, most notably 'senile melancholia', 'mania' and 'dementia'. Around the turn of the century, however, senile dementia became the most prominent, almost to the exclusion of all other forms of senile insanity. This correlates with the classificatory trends identified in the theoretical texts discussed in Chapter One: a refraction of senile insanity into its various forms in the mid-late nineteenth century, followed by a tendency, around the turn of the century, to restrict the definition of senility to 'senile dementia'. Indeed, classificatory practices at Hanwell can be related to those theoretical discussions in certain concrete ways.

In the 1840s, at the height of his fame, John Conolly gave a series of lectures at Hanwell on the 'Principle Forms of Insanity', which were published in the *Lancet* in 1845-46.<sup>27</sup> Here, he laid out a classificatory system which was essentially symptomalogical, bolstered by occasional references to Pinel and Ésquirol (although his main referent was his own observation and practice). He suggested that mania, melancholia and imbecility (which was called dementia in its advanced form) were the three main categories of insanity. These diagnoses could stand alone or have a

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<sup>26</sup> It was far more common in the 1910s for patients to be given a new diagnostic label within a few years of their admission, and for this to be recorded in the case notes. When these re-diagnoses are taken into account, the proportion of older patients in 1911-12 who were given a senile diagnosis increases to 46 per cent.

<sup>27</sup> John Conolly, 'Clinical Lectures on the Principle Forms of Insanity', *The Lancet*, 46-7 (1845-46).

‘complication’ attached: epilepsy, paralysis and hysteria.<sup>28</sup> These additional disease categories were themselves essentially symptomological: epilepsy was identified by fits; hysteria by a ‘wayward temper’; and paralysis by the very particular symptomatic trajectory of grandiosity, tremors, poor verbal articulation and then actual physical paralysis.<sup>29</sup> Conolly’s classification contained two somato-aetiological categories – puerperal and senile insanity – but he described these as separate forms of insanity, rather than sub-types of mania, melancholia and imbecility.<sup>30</sup>

The statistical tables of Hanwell show that Conolly adopted this classificatory model in his own practice: precisely the same categories appear. These symptomological categories continued to form the basis of classification at Hanwell for over a decade after the end of Conolly’s employment at Hanwell in 1852. Thus, ‘senile insanity’, supplemented on two occasions by cases of ‘senile imbecility’, were the only senile diagnoses applied at Hanwell until 1863. In the mid-1860s, however, ‘senile insanity’ disappeared from the classificatory tables, and new additions began to appear. These began on the female side of the asylum, following the appointment of a new Medical Superintendent, James Murray Lindsay, who had undertaken his medical training in Edinburgh and St Andrews.<sup>31</sup> It is not certain that he attended lectures given by David Skae, but he did begin to inject more somato-aetiological diagnostic categories into Hanwell’s classificatory tables, along with categories referring to the duration of the illness (recurrent, acute or chronic). In 1866, he gave the first diagnosis (at Hanwell) of ‘senile dementia’,

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<sup>28</sup> John Conolly, ‘Clinical Lectures on the Principle Forms of Insanity’, *The Lancet*, 46 (1845), p. 414.

<sup>29</sup> John Conolly, ‘Clinical Lectures on the Principle Forms of Insanity’, *The Lancet*, 47 (1846) pp. 171-75, 233-34, 556. Gayle Davis has noted that British psychiatrists were much slower than their French counterparts to accept General Paralysis of the Insane as a separate disease category, rather than as a ‘complication’ of insanity. W.H. O. Sankey the only Hanwell Superintendent (1855-64) besides Conolly to publish on the classification of insanity, did in fact recognise this separation. In 1864, he described GPI (or General Paresis, as he preferred to call it) as ‘entirely distinct from all other forms of mental disease’. This conviction did not, however, impact on classificatory practices at Hanwell. GPI did not appear as a separate form of insanity in Hanwell’s statistical tables until the adoption of the MPA-sanctioned classificatory system in 1885. W. H. O. Sankey, ‘The Pathology of General Paresis’, *Journal of Mental Science*, 9 (1864), p. 467. Gayle Davis, *The Cruel Madness of Love: Sex, Syphilis and Psychiatry in Scotland, 1880-1930* (Amsterdam, 2008), pp. 83-85.

<sup>30</sup> Conolly, ‘Clinical Lectures on the Principle Forms of Insanity’, p. 414.

<sup>31</sup> ‘Dr. James Murray Lindsay’, *Journal of Mental Science*, 58 (1912), p. 197.

followed by 'senile mania' in 1870.<sup>32</sup> In 1872, another Scottish-educated young doctor, Henry Rayner, joined Hanwell as Superintendent on the male side.<sup>33</sup> His classificatory style echoed Murray Lindsay's: he immediately adopted senile dementia and mania on the male side, and introduced senile melancholia.<sup>34</sup> The patient records of 1871-72, then, show Hanwell at a transitional moment.

By introducing more categories of senile insanity, Murray Lindsay and Rayner opened up new possibilities for categorising older patients' mental disorders. Now, there were diagnostic categories which could take into account both the patients' symptoms, and a potential aetiological basis in the changes of the ageing body. Patients with widely varying mental conditions – such as Richard Jeffreys who 'mope[d] and crie[d]and wishe[d] he was dead', and Esther Gurney who was 'noisy excitable and violent' and believed she was the Queen of England – could now also be labelled as explicitly 'senile' (senile melancholia and senile mania respectively).<sup>35</sup> Thus, the introduction of new categories of senile insanity allowed more patients to be labelled as senile. Hanwell's officially published statistical tables suggest that the increase in the proportion of older patients being diagnosed with senile disorders, starkly evident in Table 1, began in the mid-1870s. Simply put, the introduction of a wider range of senile diagnostic categories by Murray Lindsay and Rayner, led to a greater number of aged patients being assigned a senile 'form of insanity'. This, however, only tells part of the story. As the rest of this chapter will show, the proliferation of the words 'senile' and 'senility' to describe aged patients was not just confined to the 'form of insanity' diagnostic labels. The adoption of new categories of senile insanity, and their increasingly frequent use, was part of a wider epistemological shift, which saw aged patients, and their mental disorders, become increasingly defined by their aged bodies.

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<sup>32</sup> *The Twenty-First Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1866), p. 96; *The Twenty-Fifth Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1870), p. 91.

<sup>33</sup> R. Percy Smith, 'Henry Rayner, M.D.Aberd., M.R.C.P.Edin', *Journal of Mental Science*, 72 (1926), p. 171.

<sup>34</sup> *The Twenty-Seventh Report of the Committee Of the County Lunatic Asylum at Hanwell* (1872), p. 94.

<sup>35</sup> Richard Jeffreys, Hanwell Casebook, Males No. 12, H11/HLL/B/20/012 (1872), p. 149; Esther Gurney, Hanwell Casebook, Females No. 22, H11/HLL/B/19/022 (1872), p. 89.



Throughout this period, the MPA made sporadic attempts to bring a greater level of standardisation to the statistical tables, published by different asylums in their annual reports. In the early 1880s, whilst still working at Hanwell, Henry Rayner sat on the MPA Statistical Committee. This committee managed to produce a list of approved 'forms of insanity' in 1882.<sup>36</sup> This list, along with other tables produced by the Statistical Committee, was provisionally approved for only one year, but the Statistical Committee was not actually convened again for another twenty. In practice, the MPA had no powers to compel asylum Superintendents to adopt their standard classification, but it was (unsurprisingly, given Rayner's involvement) adopted at Hanwell in 1883, and became the standard classification for all LCC asylums after 1889. The 1882 MPA classification – which included the categories of senile mania, melancholia and dementia – did not depart in any large measure from the categories already used at Hanwell, and did not produce any discernable difference in classificatory practices at the asylum. The same cannot be said for the next version, which appeared 20 years later.

When the Statistical Committee was finally convened again in 1904, it eventually (after three attempts) produced a new, broadly accepted classification, which departed substantially from what had come before.<sup>37</sup> This need not have had any great effect on classificatory practices within individual asylums, were it not for the intervention of the Lunacy Commissioners. The Commissioners seized upon the new MPA classification as a way to extend and reinforce their wider attempts to update and standardise asylum record-keeping. The 1906 MPA classification was issued to all asylum Superintendents by the Commissioners the following year, with a corresponding set of 'codes' to be entered into the medical journal.<sup>38</sup> From this point on, classification was no longer at the discretion of individual asylum

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<sup>36</sup> 'Report of the Thirty-Seventh Annual Meeting of the Medico-Psychological Association', *Journal of Mental Science*, 28 (1882), p. 460; 'Report of Committee on the Statistical Tables of the Medico-Psychological Association', *Journal of Mental Science*, 28 (1882), pp. 462-64.

<sup>37</sup> 'Medico-Psychological Association of Great Britain and Ireland', *Journal of Mental Science*, 52 (1906), p. 480.

<sup>38</sup> 'Rules made by the Commissioners in Lunacy, 31 October 1906', reprinted in Greig, Gattie and Archbold, *Archbold's Lunacy and Mental Deficiency*, pp. 556-57.

Superintendents: the 1906 Rules of the Commissioners in Lunacy, and thus the new classificatory codes, were statutorily binding.

This literally codified classificatory system restricted the ability of asylum medical officers to express ambiguity or subtlety in their diagnostic choices. Question marks and brackets, which had previously peppered the recording of the 'form of insanity', disappeared. The categorisation of senile insanities was also significantly limited by this move towards diagnostic standardisation. Under the 1906 classification, 'senile dementia' was the only officially recognised form of senile insanity. Thus medical officers were no longer able to state (through diagnosis) that a patient's maniacal excitement, or melancholic gloom, might be partially an expression of their aged state. Medical officers, presented with a conspicuously aged patient who displayed such symptoms, were confronted with a new choice of categorisation. Did the patient's symptoms reveal the essential identity of their mental condition? Or was their old age a more important factor in their disorder? After 1907, being a senile dement was the only recognised way to be a senile asylum patient.

Although the relationship between the two was not simple, a direct line of influence can be drawn between the theoretical discussions outlined in Chapter One of this thesis, and the diagnostic patterns at Hanwell demonstrated in Table 1. This relationship was mediated by the personal preferences of the Medical Superintendents and, latterly, by decisions made by the MPA Statistical Committee, and by the needs and interests of the Lunacy Commissioners. The assignation of a 'form of insanity' to an asylum patient – and the increasing tendency to label an older patient as senile – can therefore be seen as a product of the interaction between the theory, policy and practice of psychiatry. The mid-nineteenth century saw a significant refraction of the category 'senile insanity' in psychiatric texts. An increased focus on the body, and on underlying physical states as major aetiological factors, encouraged alienists to imagine that the senile body could affect, and be

expressed through, 'all the forms of insanity usually delineated'.<sup>39</sup> Thus, senile mania, melancholia and dementia became commonly used diagnostic categories. Subsequently, however, the association of the aged body with insanity in old age led to a reversal of this process: the connection between the physiological disintegration of ageing, and the mental disintegration of dementia, was reinforced, and 'senile dementia' became the only recognised category of senile insanity.

At the end of the nineteenth century, an older person arriving at Hanwell became more likely to have their mental perturbations – however they were expressed – understood as a manifestation of their aged state. At the same time, the exclusionary discourse of senility, discussed in Chapter Two of this thesis, brought attention to the inherently aged status of older patients, and encouraged a particular understanding of senility as natural and incurable. At the beginning of the twentieth century, the restrictive classification enforced by the Lunacy Commissioners further limited the ways in which the insanity of old age could be understood: as a process of disintegrative, incapacitating, and irreversible dementia.

Standardisation did not bring about any direct changes in the way that the 'forms of insanity' were assigned to patients at Hanwell until the Lunacy Commissioners issued their classificatory codes in 1907. However, as the rest of this chapter will show, changing record-keeping practices – including increasing levels of standardisation – did have a significant impact on the way that older patients were viewed and classified at Hanwell prior to 1907. The changing classificatory habits of Hanwell's medical officers in the latter part of the nineteenth century – which saw a wider range of disorders and an increasing number of patients labelled as 'senile' – was part of a wider epistemological shift, in which greater attention was given to asylum patients' innate physical states. The aged status of older patients came to the fore in the ways in which they were described, and in the understanding of their mental disorders. This shift was reflected and engendered by changes to the format of asylum records.

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<sup>39</sup> William Bevan Lewis, *A Text-book of Mental Diseases: with Special Reference to the Pathological Aspects of Insanity* (London, 1889), p. 405.

## The Patient's Body

The physical body, though always important to understandings of madness, was at the centre of psychiatric knowledge at the end of the nineteenth century. The rise of this 'first biological psychiatry', as Edward Shorter has characterised it, did not occur in an isolated theoretical realm, but was rooted in asylum practice.<sup>40</sup> The German system, in which small psychiatric clinics were attached to universities, allowed psychiatrists to treat and observe patients in life, and then follow up their investigations immediately post-mortem.<sup>41</sup> In Britain, the relationship between care and research was more remote, but asylum patients still ultimately provided the material – in life and in death – for psychiatric theory.<sup>42</sup> The texts described in Chapter One of this thesis are filled with case studies, usually observed during the writer's regular occupation as an asylum Superintendent. After death, some asylum patients' bodies made their way to university research laboratories, contributing significantly to the education of medical students.<sup>43</sup> At the beginning of the twentieth century, laboratory practice began to encroach on psychiatric knowledge, as it had in other branches of medicine.<sup>44</sup> Gayle Davis has described the establishment of pathological laboratories for Scottish asylums at the turn of the century, and examined their use of the Wassermann test for GPI.<sup>45</sup> More recently, work on the development of asylum pathology prior to the 1890s, at the West Riding asylum in Wakefield, has painted a vibrant picture of this exceptional asylum as a 'research institution', and highlighted the interchange between asylum

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<sup>40</sup> Edward Shorter, *A History of Psychiatry: from the Era of the Asylum to the Age of Prozac* (New York, 1997), pp. 69-112.

<sup>41</sup> Eric Engstrom, 'Researching Dementia in Imperial Germany: Alois Alzheimer and the Economies of Psychiatric Practice', *Culture, Medicine and Psychiatry*, 31 (2007), pp. 406-8.

<sup>42</sup> Jennifer Wallis, 'Madness Incarnate: The Making of the Patient's Body in Late Nineteenth-Century Asylum Practice', (PhD Thesis, Queen Mary University of London, 2013).

<sup>43</sup> Elizabeth T. Hurren, 'Abnormalities and Deformities': The Dissection and Interment of the Insane Poor, 1832-1929', *History of Psychiatry*, 23 (2012), pp. 65-77.

<sup>44</sup> See, for example, the articles in Andrew Cunningham, *The Laboratory Revolution in Medicine* (Cambridge, 2002).

<sup>45</sup> Davis, *The Cruel Madness of Love*, 125-46.

patients' bodies and the development of British psychiatric knowledge earlier in the century.<sup>46</sup>

Hanwell, of course, was no Wakefield. It remained fairly removed from such scientific work, even after the opening of London's own pathological laboratory in 1895, based at the new East London Claybury asylum. Yet, through Hanwell's case books, we can also trace an increasing interest in the patient's body in the late nineteenth and early twentieth century. The new bodily practices encouraged by asylum pathology, and the orientation of psychiatric theory towards physical conditions, impacted on even relatively unscientific institutions like Hanwell. This section argues that the increasing interest in patients' bodies, and the new methods of examining and describing them demanded by the changing case book format, led to the emergence of a new category of physical condition: 'senile'. This use of this word to describe the physical condition of aged patients was almost non-existent before the turn of the century, but was commonly used in 1911-12. This in itself signalled and engendered a new way of seeing older patients: as inherently and particularly aged.

### *Describing and Examining the Body*

The amount of information gathered about the patient's body, the nature of that information, and the manner in which it was recorded, changed significantly over this period. Hanwell's case books of 1851-52 included little information about the patients' physical state. At most, the case note contained a short sentence summarising the patient's appearance: 'is feeble, much emaciated, and of a sallow complexion'.<sup>47</sup> In the 1870s, more physical observations were included, particularly regarding any cuts, marks or bruises present on admission, although these observations were inconsistently recorded, and sometimes absent entirely. At this time, the purpose of physical observation on admission was practical rather than medical: the asylum's medical officers sought to protect themselves from any

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<sup>46</sup> Michael Anthony Finn, 'The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century', (PhD Thesis, University of Leeds, 2012); Jennifer Wallis, 'Madness Incarnate'.

<sup>47</sup> Sarah Nuthall, Hanwell Casebook, Females No. 5, H11/HLL/B/19/004 (1852), p. 91.

accusations of mistreatment by cataloguing any evidence of past injuries on admission, and to broadly assess the patient's physical condition, so that their potential care needs might be anticipated.

In the 1890s, the volume and consistency of physical information included in the case notes increased significantly. Following the Lunacy Act of 1890, asylum medical officers were required to send a description of each patient's 'bodily and mental health' to the Lunacy Commissioners, which was also copied into the case book.<sup>48</sup> At Hanwell, the now-printed case book forms on the male side contained two sections for physical description: 'Condition of body on admission', containing the type of physical information previously included in the case notes, and 'Result of the Medical Examination'. This medical examination involved looking – at the skin, the eyes, the tongue, the gait – and listening – to the breath, the heart and the speech. In the female case books, the physical examination and its reporting was also guided by a more prescriptive pre-printed case book form. This form brought a measure of consistency and order to the physical observations: separate entries were often made in the spaces allotted to the 'digestive', 'circulatory' and 'respiratory' systems, and weight and pulse were almost always measured and recorded. The recording of a patient's physical condition on the two sides of the asylum thus differed in form, but not in content.

The most significant change brought about by the greater prescriptiveness of the female case books, was the creation of negative spaces. Though often left blank, the sections for which the medical officer had no particular observation to put forward were sometimes completed with a dash, or the word 'normal'. As Joel Howell has pointed out, 'Standardised forms could encourage physicians to record essential information that might otherwise be overlooked'.<sup>49</sup> Given an open space to record his observations, the medical officer could choose to examine only those elements of the patient's physical condition which he noticed to be particularly unhealthy, or pertinent to their mental state. If a patient's breathing was obviously laboured, for example, he might examine their respiratory system by listening to

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<sup>48</sup> *The Lunacy Act (1890)*, s. 38.

<sup>49</sup> Howell, *Technology in the Hospital*, p. 47.

their chest; if a patient was gripped by maniacal excitement, he might check for a fever or a rapid pulse. The prescriptive forms, on the other hand, directed the medical officer to observe and comment upon parts of the patient's body which he might otherwise have ignored, and perform acts of physical examination which, based on his overall impression of their mental state and bodily health, he might previously have deemed unnecessary. The prescriptive forms for describing a patient's physical condition thus, quite literally, directed Hanwell's medical officers to see the insane body in a new way. This new form of detailed and prescribed looking became more intense at the turn of the century.

In 1895, the LCC pathology laboratory was opened next to the new Claybury asylum in outer East London. It was designed primarily as a research laboratory; a place where post-mortem specimens from asylum patients could be examined, in the pursuit of pathological knowledge about insanity. The LCC pathologists also tested tissues from living asylum patients, most notably through the Wassermann test for syphilis, introduced at Claybury in 1909. Before the laboratory opened, Hanwell's Superintendent R.R. Alexander complained of the 'shameful waste of pathological material at Hanwell'. Though they conducted post-mortems, Hanwell's busy asylum medical officers had 'little time for more than naked-eye observations'.<sup>50</sup> In the new pathological laboratory, dead bodies were to be examined in minute detail. In the early twentieth century, this close examination of patients' bodies was extended to the living inmates of all LCC asylums. When the LCC Asylums Committee introduced the standard case book form in 1907, the most notable innovation was the increase in the size and prescriptiveness of the section on the patient's 'physical condition'. The physical information was now to be recorded onto a vast pre-printed form, taking up almost an entire page of the case book. There was little space for open answers: each piece of information to be collected was prescribed, with space for only a number or a one-word answer (usually 'yes', 'no' or 'N.' for normal).<sup>51</sup> This new physical- condition form both

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<sup>50</sup> *The Fifth Annual Report of the [LCC] Asylums Committee* (1893-4), pp. 102-3.

<sup>51</sup> These sections were not filled in directly by the medical officers, but by Maud Forbes. However, the precision and comprehensiveness of the answers suggests that, either the medical officers had their own, loose version of the physical condition form which they used when conducting their

implemented and reflected a new approach to the asylum patient's body. The detailed and prescribed list of attributes to be examined and described supplied a method for revealing the hidden reality of the patient's underlying disorder, beyond that which was immediately obvious. Through this form, the patient's body was fragmented: not just into the digestive, nervous and vascular system, but into teeth, gums and tongue; irises and pupils; capillaries and veins. It represented a new drive to look beyond the unified patient and their overall condition, and to probe the secret pathological processes, hidden deep within the body and revealed through its disaggregated parts.

### *The Senile Body*

In the 1911-12 case books, the first category on the new physical condition form is 'General bodily condition', with space for a one-word answer. Often, that answer was a general term such as 'fair', 'weak' or 'feeble', seemingly designed to indicate the place of the patient along a continuum of physical health. These were not, however, precisely or routinely applied labels, designed for statistical analysis. In some cases, a particular disease or physical condition was written into this space, such as 'hemiplegic' or 'morbis cordis'.<sup>52</sup> One patient was described as 'weakish'.<sup>53</sup> Sometimes, the word 'condition' was crossed out and the word 'health' written in its place, though this had no discernable effect on the type of answer given. The meaning of this category, then, was ambiguous, but its purpose seems to have been to give a headline summary of the patient's physical state. This category had been present in former years, though in a less strictly codified way. In the 1870s, the female case notes usually included a two-word description of the patient's health in the margin of the first page, stating 'weak health' or 'fair health'. In the 1890s, physical descriptions sometimes began with a general statement, such as 'is extremely feeble, weak health, body very thin'.<sup>54</sup> The creation of the 'General bodily

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examinations, or that they had memorised its contents and internalised the type of examination it prescribed.

<sup>52</sup> Thomas Davidson, Hanwell Casebook, Males No. 31, H11/HLL/B/20/040 (1911), p. 13; Joseph Salling, H11/HLL/B/20/040 (1911), p. 26.

<sup>53</sup> Aaron Priest, Hanwell Casebook, Males No. 30, H11/HLL/B/20/039 (1911), p. 61.

<sup>54</sup> Bridget Harley, Hanwell Casebook, Females No. 14, H11/HLL/B/19/037 (1891), p. 37.



condition' category, then, like many elements of the 1907 case book, was a way of regulating and prescribing a practice which was already taking place.

While the practice of offering this general statement on bodily health was not new, by 1911 a new way of responding to it had emerged: the word 'senile'. It was used to describe almost all the patients over 70, but was also attached to a significant number of patients in their 60s, from as young as 62. Old patients might be weak or feeble, but – if labelled 'senile' – their weakness was understood to be manifesting in a way that was intrinsically connected to their age. This term was being used to indicate the presence of a specific, identifiable process which was taking place within the patient's body, with certain predictable effects. Earlier case notes point to a similar understanding of the ageing process. In 1892, 72-year-old James Shaw was described as 'a very feeble old man with all the evidences of senility well marked'. From at least the 1890s, then, senility was viewed as an underlying constellation of physical changes, which went beyond general enfeeblement, and which left specific 'evidences' on the body. These included phenomena visible on the body (such as *arcus senilis*, or grey hair), phenomena visible through observation and examination (such as poor mobility, 'senile' tremors, deafness or blindness) and phenomena whose presence within the body was indicated by other bodily signs (such as arteriosclerosis).<sup>55</sup> In the 1890s, Hanwell's doctors knew how to identify a 'senile' body, but rarely did so. By the 1910s, when the more prescriptive case book forms demanded a more rigorous investigation of the physical signs displayed by patients' bodies, the description of a patient as 'senile' had become commonplace.

There was no Wasserman test for senility, and senescence could not be identified in a laboratory. Gayle Davis has argued that the 'rhetorical... utility' of the Wassermann test, as a symbol of scientific practice, was more important than its

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<sup>55</sup> There is no indication in the asylum records as to how arteriosclerosis – a thickening and hardening of the arterial walls – was diagnosed in living patients. Contemporary medical texts suggest that a wide variety of signs were used, including shortness of breath, a quick pulse, an elevated temperature, 'radiating pains' and general 'weakness'. Alfred Stengal, 'Some Clinical Manifestations, Visceral and General, of Arteriosclerosis', *The British Medical Journal*, 2 (1906), p. 1010.

'practical utility'.<sup>56</sup> The emergence of the senile patient shows that a new laboratory test was not needed for a new type of patient to emerge; the rhetorical turn towards the body was enough to encourage a significant change in the way that older bodies were categorised and viewed. The 'evidences' of old age were all identifiable prior to 1900, and mostly visible without close examination. Nevertheless, the increased interest in the bodies of the LCC's asylum patients – fostered by and reflected in the opening of Claybury's pathological laboratory, and engendered by the newly detailed physical condition form in the case notes – had a significant impact on the way that older bodies in the asylum were viewed. The use of the physical descriptor 'senile' in the early-twentieth-century case notes signifies a new awareness of a specifically 'senile' body, part of the overall growing tendency to view older patients as inherently and distinctively senile. This mirrors Stephen Katz, Andrew Achenbaum and Carole Haber's findings, on the development of new understandings of the aged body in nineteenth-century medicine.<sup>57</sup> As pathological anatomy took on increasing importance in the understanding of disease and the body, the physical markers of old age became more visible, prompting a new definition of old age which 'separated it medically from all other age groups'.<sup>58</sup> According to Katz, age was thus reduced to its physical signs: stripped of macrocosmic, spiritual and social meaning, '[w]hat could be said about old age depended on what could be seen of it in the body'.<sup>59</sup> He draws on Foucault's argument from the *Birth of the Clinic*, that changes in medical practice ruptured the relationship between the patient and their illness, and reduced understandings of disease to the identification of specific pathological processes. Thus, the patient went from being the 'subject' of his disease to 'the accident of his disease, the transitory object that it happens to have seized upon'.<sup>60</sup> This objectification created new categories, and drew all bodies displaying similar pathological traits into a defining relationship with one another. Katz and Haber argue that 'senescence' became identifiable in the same way as different diseases: as a universal process

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<sup>56</sup> Davis, *The Cruel Madness of Love*, p. 241.

<sup>57</sup> Achenbaum, *Old Age in the New Land*, pp. 42-47.

<sup>58</sup> Haber, *Beyond Sixty-Five*, p. 58.

<sup>59</sup> Katz, *Disciplining Old Age*, p. 30.

<sup>60</sup> Foucault, *The Birth of Clinic*, p. 72.

which acted on the body in certain predictable ways, the traces of which could be seen on or in the aged body. Thus, as Katz puts it, the increased interest in the pathological markers of ill and aged bodies 'configured a new subjective identity based on the imaginary unity and self-referentiality of the human body in old age'.<sup>61</sup>

On a more modest scale, the case notes of Hanwell suggest a similar process. Between the 1850s and the 1910s, the aged body became more visible in the asylum on both a macro- and micro- level. By 1912, there were far more aged bodies in Hanwell than there had been 50 years previously: more grey hair, more wrinkled skin, more stooped stances and trembling limbs. At a micro-level, insane bodies of all ages were being minutely examined at the LCC pathological laboratory. On admission to Hanwell, patients' bodies were more closely scrutinised than ever before: not just for bruises and scars – signs of lived experiences – but for signs of internal pathological processes, including senescence. The increased visibility of aged bodies, and of the signs of ageing, spurred on the creation of a new, unified category of bodily type, into which older patients could be organised: the senile.

### **Aetiology and the Lay Narratives**

In their pioneering study of Colney Hatch Asylum in the nineteenth century, Ida McAlpine and Richard Hunter described 'a reorientation of psychiatry from listening to looking'.<sup>62</sup> At Hanwell, 'looking' – represented in the case books through the physical description sections – progressively displaced the practice of 'listening' to patients' friends and families, as the central means through which knowledge about a patient's condition was acquired. This shift was reflected in the 'causes of insanity' ascribed to each patient, which similarly shifted from the biographical and experiential, to the physical. This led to, and was reflected in, an increasing tendency to ascribe the mental disorders of older patients to 'senility'.

The practice of listening was well embedded at Hanwell in the mid-nineteenth century. During his tenure as Medical Superintendent in the 1840s, John

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<sup>61</sup> Katz, *Disciplining Old Age*, p. 47.

<sup>62</sup> Richard Hunter and Ida Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum--Friern Hospital 1973: a Medical and Social History* (Folkestone, 1974), p. 184.

Conolly had begun interviewing new patients' friends and relatives, in order to ascertain the cause of their disease. Akihito Suzuki has analysed a series of these so-called 'lay narratives' from the male case books of the 1840s. Suzuki presents the lay narratives as a reasonably direct representation of an authentic lay aetiology; a window into the understanding of madness and its causes in working-class communities.<sup>63</sup> Suzuki's study ends just as this one begins. This section will trace the development of the lay narratives from the early 1850s to the beginning of the twentieth century. Up to the 1870s at least, the aetiological factors identified by the lay narrators at Hanwell were often legitimised as the official cause of insanity. Over the course of this period, however, the lay voice was increasingly marginalised within the case books. Printed forms placed new restrictions on the eliciting and recording of lay knowledge, and by 1911 the 'physical condition' form had literally displaced the lay narratives in the case books. Traces of a distinctive lay aetiology, which tended to prioritise life experiences over physical phenomena, remained. By the early twentieth century, however, it had been largely expunged from the official record of the asylum, now guided by the codified categories of the medical journal. The body was increasingly viewed as the seat of insanity and physical causes, including old age, were prioritised over psychological ones in the list provided by the MPA. The marginalisation of the lay voice can thus be coupled with the rise of senility as a cause of insanity. By the early twentieth century, aged patients were largely removed from their biography – an epistemological shift which was reflected and engendered by the format of the patient records – and had instead become thoroughly embodied.

### *Economic Anxiety*

In his study of lay narratives dating from the 1840s, Suzuki found that the 'worry' caused by loss of employment, or other pecuniary difficulties, was the most prominently featured aetiological factor.<sup>64</sup> This continued to be the case throughout

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<sup>63</sup> Akihito Suzuki, 'Lunacy and Labouring men: Narratives of Male Vulnerability in Mid-Victorian London', in Roberta E. Bivins and John V. Pickstone (eds), *Medicine, Madness, and Social History: Essays in Honour of Roy Porter* (Basingstoke, 2007), pp. 119, 126.

<sup>64</sup> Suzuki, 'Lunacy and Labouring Men', pp. 121-26.

this period. Even when friends and relatives described other potentially traumatic phenomena, they often emphasised the effect these had on the patient's employment prospects, and the anxiety this caused them. Some years prior to his admittance to Hanwell in 1852, Thomas Stokes' arm was injured. He underwent significant pain and difficulty as a consequence of this, including a rather alarming-sounding procedure called 'exfoliation of the bone'. It was however the 'grief at [his] inability to work' due to the state of his arm, rather than anything connected to the injury itself, which was described as the cause of his insanity.

The effects of a patient's age on their ability to find and retain employment was often mentioned in these narratives. Retirement was a possibility for only a minority of older people in this period. Friendly societies – mutual assurance co-operatives into which some poorer workers paid in an attempt to protect themselves from later poverty – offered some hope for those who were too debilitated to work, and Poor Law out-relief was more widely available to old people than to others, but for most, continued employment was necessary to avoid the dreaded fate of ending their days in the workhouse.<sup>65</sup> Of course, this was not always possible. At the age of 74, Richard Cullen had become unable to find work, 'owing to age and infirmity'. Without earnings he was eventually forced to withdraw his savings from the bank. According to his son, he 'fretted at this', and soon began to show signs of mental infirmity.<sup>66</sup> James Rourke's 'fretting' was apparently caused by being 'passed by in the labour market for younger men'.<sup>67</sup> At the age of 63, carpenter James George Charlick was told by his employers that he was 'too old to take a change of jobs'. His wife had 'struggle[d] to keep the home together' over the following three years, before James was admitted to Hanwell, but she told the medical officer that 'the pinnacle of poverty was very keen'.<sup>68</sup> This is the manner in which old age appears in these narratives: not as a pathological process leading to mental disintegration, but as a practical barrier to the maintenance of a stable life. According to these lay interpretations, it was not the

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<sup>65</sup> John Macnicol, *The Politics of Retirement in Britain, 1878-1948* (Cambridge, 1998), pp. 18-59.

<sup>66</sup> Richard Cullen, Hanwell Casebook, Males No. 10, H11/HLL/B/20/010 (1871), p. 111.

<sup>67</sup> James Rourke, H11/HLL/B/20/010 (1871), p. 191.

<sup>68</sup> James George Charlick, Hanwell Casebook, Males No. 12, H11/HLL/B/20/021 (1891), p. 223.

physical decline of old age which caused mental infirmity, but the psychological hardships faced by the aged. Karen Chase has described the importance of issues surrounding work (or the lack thereof) and poverty to the late-nineteenth-century understandings of old age.<sup>69</sup> The mental strain placed on the aged by their difficult financial position was not lost on the campaigners for the welfare of the aged poor, and formed a part of the justification for old-age pensions.<sup>70</sup> These asylum narratives offer a stark reminder that the biggest concern facing many old people in this period was not failing health, but the looming fear of the financial hardships it might bring.

In his article drawn from these narratives, Akihito Suzuki situates male patients' anxieties over the loss of work in the context of the rise of a 'new working class respectability and concomitant notion of manhood'.<sup>71</sup> He draws on Anna Clark's argument that the role of the 'male breadwinner' became established in the first half of the nineteenth century, relegating women to the domestic sphere, and moving men to the economic centre of the family.<sup>72</sup> According to Suzuki, the prominence of economic anxieties in men's case histories indicates a particularly masculine form of mental strain occasioned by this breadwinner role. The burden of primary economic responsibility, Suzuki argues, and the fear of failure in this task, 'tormented [the working man's] psyche'.<sup>73</sup> The fear of loss of economic independence, and of letting down the family, is undoubtedly present on Hanwell's male side in this later period. When John Wyburn Hills was 'let go' by the company where he had worked for 37 years, 'because he was getting too old for his work', he was referred to the Charity Organisation Society. It was this act of dependency and the humiliation it occasioned which, according to John's son,

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<sup>69</sup> Chase, *The Victorians and Old Age*, pp. 244-45.

<sup>70</sup> See, for example, Booth, *Aged Poor in England and Wales*, pp. 196-7; Charles Booth, *Old Age Pensions and The Aged Poor: A Proposal* (London, 1899), p. 8.

<sup>71</sup> Suzuki, 'Lunacy and Labouring Men', p. 118.

<sup>72</sup> Anna Clark, *The Struggle for the Breeches: Gender and the Making of the British Working Class* (Berkeley, 1997), as referenced in Suzuki, 'Lunacy and Labouring Men', pp. 127-28.

<sup>73</sup> Akihito Suzuki, 'Lunacy and Labouring men: Narratives of Male Vulnerability in Mid-Victorian London', in Roberta E. Bivins and John V. Pickstone (ed.), *Medicine, Madness, and Social History: Essays in Honour of Roy Porter* (Basingstoke, 2007), p. 128.

‘preyed on his mind’ and led to his insanity.<sup>74</sup> When 81-year-old Henry Arnold was admitted to the asylum, his daughter suggested that it was ‘seeing his wife in want’ which had caused him the most worry.<sup>75</sup> Similarly, Emma Greenstreet and Elizabeth Barnard’s husbands mournfully explained to Hanwell’s medical officers that it was their failures in business which had caused their insanity.<sup>76</sup>

However, Hanwell’s case notes demonstrate that economic responsibility, and the anxieties it caused, was not an exclusively male concern. Single and widowed women, and those with irresponsible, ill or incapacitated husbands could not rely on a male breadwinner for their economic stability. One widowed patient had successfully run her husband’s chimney-sweeping business for a decade after his death, while another kept a bakery shop; in both cases, decline in business, and the worry it caused them, was named as the cause of their insanity.<sup>77</sup> Old age affected women’s abilities to earn a living as much as men’s. According to 71-year-old Rebecca Arden’s daughter, she had become melancholy due to being ‘poorly off in consequence of her not being able to work in consequence of her advancing years’.<sup>78</sup> As workers and business owners, or as women dependent on economic troubles could also have a significant impact on older women’s mental health, a fact which was recognised in the case histories.

Economic anxieties were marginally the most frequently-cited cause of insanity in the case notes, but there were many others. Anxiety caused by domestic situations was also frequently cited in these narratives, in both the male and female case books. Families could be a source of concern as much as a source of care, and many of Hanwell’s older patients were worried about feckless adult children, or cruel spouses.<sup>79</sup> Grief was another commonly mentioned aetiological factor. While most of the lay narratives refer to these kinds of emotional or mental distress, there

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<sup>74</sup> John Wyburn Hills, Hanwell Casebook, Males No. 13, H11/HLL/B/20/022 (1892), p. 179.

<sup>75</sup> Henry Arnold, H11/HLL/B/20/021 (1891), p. 517.

<sup>76</sup> Emma Greenstreet, Hanwell Casebook, Females No. 13, H11/HLL/B/19/036 (1891), p. 214; Elizabeth Barnard, Hanwell Casebook, Males No. 2, H11/HLL/B/20/002 (1851), p. 632.

<sup>77</sup> Emma Matilda Hasilton, H11/HLL/B/19/063 (1912), p. 98; Elizabeth Geisel, H11/HLL/B/19/063 (1912), p. 41.

<sup>78</sup> Rebecca Arden, H11/HLL/B/19/021 (1871), p. 73.

<sup>79</sup> See pp. 161-65.

are also references to accidents and injuries, illnesses, other physical conditions, such as sunstroke, and intemperance. Amongst this wide range of causes, however, there are no explicit references to the ageing process itself. This suggests that, outside of the asylum, insanity of old age (as at other ages) was still broadly understood in the context of a person's biography. Within this lay aetiology, the troubles of the ageing mind were more likely to be attributed to difficult or harmful experiences, than to problems associated with the aged body.

### *The Marginalisation of the Lay Voice*

The same themes – economic anxiety, domestic trouble, grief and injury – persisted in the lay aetiology of insanity from the 1850s to the 1910s. However, that lay aetiology becomes increasingly difficult to discern in the case books. The latter part of the nineteenth century saw a significant marginalisation of the lay voice in the case books and with it, a decreasing reliance on the lay aetiologies described above. Akihito Suzuki has described a similar change in the case books of mid-century Bethlem. He suggests that the case notes of Bethlem, prior to 1852, deal with two different chronological phases: the patient's life before institutionalisation, and after. Knowledge of the former phase – in which the person made the journey from sanity to madness – was considered essential to a full understanding of the mental disorder. However, it was knowledge that the doctors could not access without an outside informant. Thus, the lay narrators who were invited to supply this information 'had a clear epistemological advantage over the doctors, because they usually observed the crucial transitional process first hand'. Because of this 'epistemological advantage', Suzuki suggests that the doctors were compelled to record the lay narratives in a fairly direct way, rendering these texts useful as reasonably unmediated accounts of lay understandings of insanity. The ideas contained within these narratives formed a key part of the medical knowledge which was constructed around the patient in the case books.<sup>80</sup> At Bethlem, however, the ascendancy of lay aetiologies was suddenly and decisively overthrown in 1852, when a new Superintendent, William Hood, took charge. He

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<sup>80</sup> Suzuki, 'Framing Psychiatric Subjectivity: Doctor, Patient and Record-Keeping in the Nineteenth Century', in Melling and Forsythe (eds), *Insanity, Institutions and Society*, pp. 117-22.



did away with the lay narratives, and instead came to his own conclusion as to the cause of his patients' insanity, through intensive one-on-one interviews. At Bethlem, then, there was a 'disenfranchisement of the family as a proper component of psychiatric discourse'.<sup>81</sup>

Although there was no such dramatic change at Hanwell, the second half of the nineteenth century did see a progressive marginalisation of the lay voice in the case notes, and in the ascription of the cause of insanity. Through Hood's interviews, Suzuki suggests, the patient's own voice came to replace the voice of the lay narrators in the case notes, shifting the emphasis over to the other side of the patient-doctor-narrator knowledge 'triangle'.<sup>82</sup> This was not the case at Hanwell. Hanwell's patients were not asked to give an account of their condition in the same way as those who were interviewed by Hood at Bethlem. However, the increasingly detailed practices of physical examination and description, outlined above, called upon the patients' bodies to 'speak' to the underlying cause, and nature, of their mental disorder. The practice of soliciting information from a patient's friends and family members continued throughout this period. However, there were increasing limitations placed on the type of information solicited, and the manner in which it was recorded. The connection between the family narratives and the medical classification of Hanwell's patients decreased significantly, as drives towards standardisation – along with the enhanced emphasis on underlying physical pathologies – produced a more restricted aetiological framework.

### *Recording the Lay Narratives*

As with other sections of the case note, the manner in which the lay narratives were recorded changed over this period. In the 1850s and 1870s, the case histories were recorded into the case books as straight prose. As with the physical descriptions, there was a level of regularity to the way that case histories were recorded, even prior to the introduction of a prescribed form. Certain recurring themes indicate the types of questions being asked by the medical officers regarding, for example,

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<sup>81</sup> Suzuki, 'Framing Psychiatric Subjectivity', pp. 123-28.

<sup>82</sup> Suzuki, 'Framing Psychiatric Subjectivity', p. 116.

past injuries, pregnancies, traumas and habits. At the same time, the open framework gave more scope for families and friends to guide the interview and shape the narratives, which are consequently varied in content and emphases. In the 1890s, the prescribed forms brought more order to the lay narratives. In 1891-92, the male case book forms provided dedicated, but open, spaces for the patient's 'family' and 'personal' history. On the female side there was a more prescriptive form, with 29 categories and questions, eliciting information about children, previous attacks, and habits. At this time, however, the prescribed form and the open narrative coexisted, and the open narratives were just as long as they had been in the 1870s.

This coexistence wilted following the introduction of the 1907 case book. Here, there were 48 prescribed questions under the 'case-history' form, on both the male and female sides. There was still comparable space allotted to an open narrative of the case history, but this was pushed to the third page of the case note, and often left blank. The open narratives which were written were generally much shorter. Hanwell's medical officers thus continued to elicit information about the patient's history from friends and relatives, but in a much more limited way. The space for lay narrators to provide their interpretation of their friend or relative's insanity was pushed aside; now, they were firmly positioned as providers of objective information, for the medical officer to interpret. Just as the increasingly prescriptive 'physical condition' form directed the medical officers to examine the body more intensively, seeking signs of disorder which might be hidden from view, so the new case history form called upon the lay narrators to provide information about the patient's life which they may not have considered particularly relevant to their insanity. The lay narrators' interpretation of the patient's condition was no longer deemed relevant: the prescribed forms were designed to reveal the objective aetiological reality underlying the patient's condition.

Throughout this period, families who could not visit the asylum directly were asked to send a letter providing details of the case history, many of which are

stuck into the case books. By 1911, friends and family members were being sent a form to fill out. It is unclear to what extent this 'Inquiry Form' replaced face-to-face interviews, as the information was usually transcribed into the case book. The sparseness of many of the case-history forms in the 1911-12 case books suggests that the use of postal interviews may have been quite common. The first two pages of the inquiry form contained limited questions about the patients themselves, although only two out of the 23 related directly to the current attack. The rest concerned the patient's childhood development, physical health, habits, and personal history of insanity. A full third page was allocated for questions about the patient's family, with informants asked to provide information about the death, health and habits from a wide range of family members, from parents to their cousins. The final, full page was left blank, with the title 'Additional Information', soliciting 'any other facts' about the patient. The form is attached, rather than transcribed, in one case in this sample, sent by the brother of a patient called Joseph Murphy, admitted in 1912.<sup>83</sup> Joseph's brother had not seen him for ten years, and appeared to know little of their shared family history. Thus, most of the prescribed questions are answered with 'unknown'. The final page, however, is half-full, with Joseph's brother's own interpretation of his mental state. He explained that his brother had never had steady work, and that he had been sending him money for some years. He speculated that the recent sinking of the Titanic may have aroused memories of an accident at sea which Joseph had experienced some years before. He wondered how this attack could have come on so suddenly, as Joseph's recent letters had seemed quite sane. These were details he found important, but could find no place for in the prescribed form. This example, then, demonstrates the limitations of the inquiry form for expressing the knowledge and interests of the lay informants. Information which Joseph's brother deemed pertinent could not be contained within the prescribed categories, while the asylum's own questions and interests were of little relevance to his relationship with his brother, and his knowledge of him. There may have been other inquiry forms like this, full of

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<sup>83</sup> Joseph Murphy, H11/HLL/B/20/040 (1912), p. 139.

observations which were never transcribed into the case book, made irrelevant by the drive for codification and standardisation.

As the lay narratives became more standardised, the emphasis on heredity and family medical history grew, even in the case of aged patients. In the 1850s, insane parents or siblings were occasionally mentioned in the narratives, but there was usually no reference to heredity. By 1871, the medical officers were actively seeking out a family history of insanity, entering 'not hereditary' into the case books if none could be found. Thus, the status of a patient's insane heredity was demonstrated to be central to the understanding of their mental disorder. In 1891-92, the volume and scope of information about the family history included in the case books had significantly expanded. On the male side, the space allotted to the patient's 'family history' and 'personal history' were of equal size. On the female side, specific questions about the patient's family were included in the case book form, regarding any family history of insanity, nervous disorders, phthisis and intemperance. On both sides, the printed case book form provided a space to indicate if there was any 'consanguinity' in the patient's hereditary past. The female case book also contained a space for the general 'habits' of the parents. An insane inheritance was thus not all that was at stake: the entirety of their underlying genetic makeup, revealed through the habits and health of their parents, was now thought to have a bearing on their mental condition. In the 1907 case book, an extended list of family members was included in the section on family history. Now, it was not just the health and habits of a patient's siblings and parents that were elicited, but their cousins, aunts and uncles, and nieces and nephews.

The increasingly precise questions about the patient's family history probed the hidden realities of their mental disorder. Just as the detailed physical examination sought signs of underlying pathology – buried deep within the body and potentially displayed by minute or seemingly innocuous external signs – the detailed investigation of the patient's family history was designed to reveal the hidden pathologies in the patient's genetic past. In theoretical terms, an insane

heredity was usually regarded as unnecessary for the manifestation of senility insanity. A 'neurotic inheritance' might weaken a person's resistance to the damaging effects of ageing, and potentially bring on senility prematurely, but a person with no family history of insanity could still succumb to senility.<sup>84</sup> Indeed, in many ways, senility reproduced the effects of an insane inheritance: both conditions constituted a constellation of potentially damaging physical circumstances, which could give rise to mental disorder, and alter its course. The growing emphasis on heredity was another manifestation of the increasing emphasis on the somatic aetiology of mental disorder: a dangerous potentiality, embedded within the patient's physical structure.

### *Senility as a Cause of Insanity*

In the 1850s, the cause of insanity was entered into the admissions book. Although it was spatially removed from the narratives recorded in the case books, particularity and individuality of the lay aetiology found in those narratives were preserved. For example, the cause of insanity entry in the admissions book for one patient reads 'anxiety about a lock which he was making for the great exhibition in Hyde Park' and 'overwork and loss of rest while engaged upon the lock'.<sup>85</sup> In the 1870s, the recorded causes were usually more general: 'domestic troubles' or 'anxiety over work'. Nevertheless, the contribution of the individual narratives in informing the doctor's estimation of the 'cause of insanity' remained strong. In the female case book of 1870s, the cause of insanity was recorded on the second page of the case book, alongside the rest of the patient's case history. In the 1890s, the space for the cause of insanity was printed alongside the case history form. Aetiological knowledge, then, was spatially and conceptually embedded within the patient's history, accessible only through the reports of lay informants.

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<sup>84</sup> T. S. Clouston, *Clinical Lectures on Mental Diseases* (London, 1883); pp. 564-66; T. S. Clouston, 'An Address Delivered At The Opening Of The Section Of Psychology. The Neuroses And Psychoses Of Decadence', *The British Medical Journal*, 2 (1898), p. 303; Charles Mercier, *A Text-book of Insanity* (London, 1902), p. 46; Bolton, 'Amentia and Dementia' (1906), p. 429.

<sup>85</sup> Register of Male Admissions (1839-1853), H11/HLL/B/04/001.

In the first decade of the twentieth century, however, the codification brought about by the 1907 Order of the Lunacy Commissioners pushed this lay aetiology to one side. Codes were provided for a standard list of the 'causes of insanity' to be entered into the new medical journal, as they had been for diagnoses. These were overwhelmingly somatic: of the 53 listed, 51 related to a physical illnesses (such as tuberculosis), conditions (such as senility), activities (such as masturbation) or experiences (such as sunstroke). The two others were 'sudden mental stress' and 'prolonged mental stress'.<sup>86</sup> The precise details of a patient's life experiences were thus rendered irrelevant. In 1911-12, the case book still contains a space to record the cause, as it was reported by the lay narrator, but it was now explicitly labelled as such: 'causes ascribed by friends'. Sometimes, the entries made to the medical journals represented these ascribed causes, but often they were entirely different. At the beginning of the twentieth century, then, lay aetiologies were significantly excluded from the official records of the institution. The doctor's own assessment, guided by the categories provided by the Lunacy Commissioners and the MPA, had taken over the formation of knowledge about insanity.

Unsurprisingly, the increased focus on a patient's physical state as a cause of their insanity, and the marginalisation of life experiences in Hanwell's aetiological framework, led to a significant increase in the number of older patients whose insanity was assigned to their 'senility'. Quantifying the 'cause' of insanity in the case notes over time is not simple, as the way in which causes were recorded changed over time. Taking into account all parts of the case note in which a cause was recorded, including those provided explicitly by the lay narrators, and those recorded using the 1907 schedule, the proportion of cases aged 60 or over in which 'senility' or 'old age' was given as a cause of insanity rose from 6 per cent in 1871-72, to 42 per cent in 1891-92. It then dropped to 30 per cent in 1911-12. In 1851-52, old age did not appear as a cause in a single case, although it was included as a category in Hanwell's official tables. This mirrors the pattern of 'senile' diagnoses

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<sup>86</sup> NHS/P12.

shown earlier in Table 1.<sup>87</sup> These classificatory changes demonstrate that agedness was increasingly accessible within the medical officers' practical epistemology, as a defining characteristic of older patients.

## Conclusion

This chapter has argued that new practices of looking and recording – driven by an epistemological imperative to probe the insane body for indications of their underlying pathology – made the agedness of old bodies more visible. At the same time the marginalisation of patients' individual life stories allowed their experiential differences to be overshadowed by their shared physicality. Thus, the 'senile' emerged as a distinct group of patients, whose bodies and minds were indelibly marked by their age. This is reflected in the increased use of the words 'senile' and 'senility' to describe the form and cause of older patients' mental conditions, and their physical condition.

These mutations can in turn be related to the theoretical changes outlined in Chapter One, and the discursive differentiation of the 'senile' described in Chapter Two. Through the innovations of fresh, young Medical Superintendents, changing trends in record-keeping practices, and the direct intervention of the LCC and the Lunacy Commissioners, changing theoretical models of insanity entered asylum practice. The concerted attention paid to somatic aetiology which emerged in the third quarter of the nineteenth century, and the determination to relate that aetiology to the classification of mental disorders, was made explicit in the published writings of psychiatrists, but was also reflected and extended in asylum practice through the changing format of the patient records. As argued in Chapter One, the focus on somato-aetiology brought fresh attention to senility as a key factor in older people's mental disorders. In theory, this was expressed through the multiplication of senile insanities employed in different psychiatrists' classificatory

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<sup>87</sup> As these figures suggest, not every case which was given a 'senile' diagnosis was also assigned 'senility' as a cause in the case notes. While this may represent something interesting about the conceptualisation of aetiology and the aged body, and of the way that 'senility' as a state of being was understood, it is more likely to be a product of inconsistent record-keeping practices.

schemes. In practice, it was reflected in the increasing frequency with which senility was used to describe older patients.

Furthermore, the increasing visibility of older patients, as a problematic group in the asylum, was echoed and reinforced by the increasing visibility of the physical signs of ageing in older patients. The burgeoning attribution of aged patients' disorders to their senility both confirmed and was, perhaps, encouraged by, the fear of an ever-worsening senile burden. However, the exclusionary discourse of senility, described in Chapter Two, did not operate within the asylum in the same way as it did in those more externally directed reports. Through their interventions in the death and discharge of older patients, Hanwell's medical officers showed that they were committed to the care of even the most decrepit patients when they were actually in front of them, and that they understood that they had a role to play in easing the sufferings of the most unpromising of cases. This will be examined further in the final chapter.



## Chapter Five: Leaving the Asylum; the Death and Discharge of Aged Patients

As discussed in Chapter Two, aged patients' proximity to death was often cited as a reason to exclude them from asylum care. In his annual report from 1875, Hanwell superintendent, Henry Rayner, complained that

in several instances [newly admitted] patients have been so old and feeble, that they have had to be carried direct from the vehicle that brought them to bed, and there they remain until they die...Should this practice still be continued, some one of them, sooner or later, will die on the journey.<sup>1</sup>

Rayner's fears were never realised: there are no reports, up to 1912, of a patient dying on the journey to Hanwell, although several patients died within days of arriving at the asylum. Broadly speaking, Rayner's concerns about the morbidity of aged admissions were well founded, but not all-encompassing. As Figure 6 shows, at least 60 per cent of patients in this sample died in the asylum, but at least 30 per cent were discharged or transferred. Most aged admissions to Hanwell died, and some died quickly, but a sizeable proportion left the asylum alive.

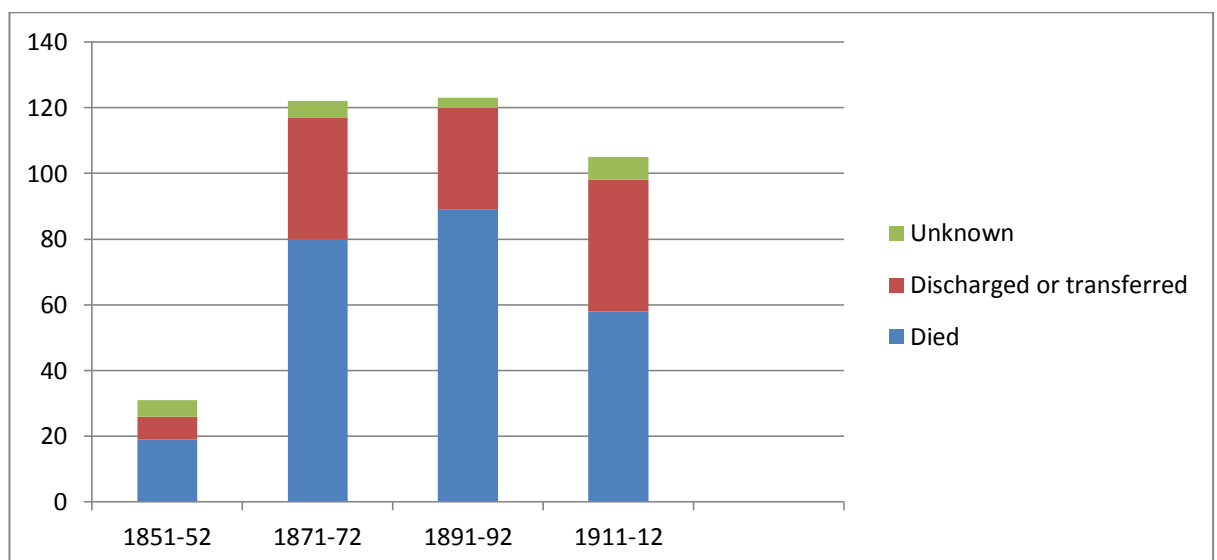


Figure 6. Outcome of residence of patients aged 60 or over on admission at Hanwell, 1851-1912.

<sup>1</sup> *The Thirtieth Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1875), p. 23.

This chapter will consider the two ways out of the asylum – death and discharge – in turn. It will look at the role of asylum medical officers, attendants and managers, and at the role of the patients and their families, in both of these events. A counterpoint to some of the claims discussed in Chapter Two will be offered; for example, the chapter will show that some patients' families were eager to have them home, and to take over their care. Similarly, it will show that the asylum superintendents were not always eager to see old, decrepit patients removed from their care. Ultimately, however, the evidence does not support an optimistic assessment of aged admissions' chances of life after Hanwell. Indeed, the case notes of aged patients are particularly useful for providing an insight into the experience and management of death in the asylum.

## Dying and Death

Death was a constant presence at Hanwell. Between 1860 and 1900, a patient died, on average, every two days.<sup>2</sup> Attending to the dying was thus a quotidian feature of asylum life for the doctors, nurses and attendants.<sup>3</sup> On Hanwell's crowded wards, few patients died alone and, although attempts were made to contain it, the spectre of death hung over the patients and staff of Hanwell alike.<sup>4</sup> As Jonathan Andrews has recently noted, death and dying are currently given scant coverage in asylum historiography,<sup>5</sup> with dying particularly neglected. The dead body was central to the creation of psychiatric knowledge in the late-nineteenth century, and so there have been studies of pathology, of post-mortems, and of the movement of

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<sup>2</sup> Hanwell's annual reports indicate that 6505 patients died at the asylum between 1860 and 1900.

<sup>3</sup> Historians Pamela Michael and Jonathan Andrews have suggested that patients were also involved in attending to the dead in the asylum. There is no direct evidence of this in the records at Hanwell, but the case notes do record the presence of other patients at the moment of death. Pamela Michael and David Hirst, 'Recording the Many Faces of Death at the Denbigh Asylum, 1848–1938', *History of Psychiatry*, 23 (2012), p.42; Jonathan Andrews, 'Death and the Dead-house in Victorian Asylums: Necroscopy Versus Mourning at the Royal Edinburgh Asylum, c. 1832–1901', *History of Psychiatry*, 23 (2012), p. 9.

<sup>4</sup> Jonathan Andrews has found evidence of 'graveyard humour' in references to death in Morningside Asylum's patient publication, *The Morningside Mirror*, whose writers made wry references to post-mortem and the asylum's disposal of the dead. Andrews, 'Death and the Dead-house in Victorian Asylums', pp. 8, 13.

<sup>5</sup> Jonathan Andrews, 'Introduction: Lunacy's Last Rites', *History of Psychiatry*, 23 (2012), p. 3.

dead bodies from the asylum to anatomical research schools for dissection.<sup>6</sup> Nineteenth-century psychiatrists were far less interested in the dying body, and this gap in interest has translated into a gap in the historiography. A recent collection of essays on death and the asylum included discussions of causes of death, attitudes towards death, and the disposal of dead bodies, but contained little mention of the experience of dying in the asylum.<sup>7</sup> This lack of attention to *dying* as opposed to *death* is not unique to asylum historiography. As Clare Humphreys has noted, in a unique study of hospice care in nineteenth-century Britain, the meaning and mourning of death has drawn significant interest from historians of this period, but 'the dying person' themselves has been neglected.<sup>8</sup> Pat Jalland's *Death in the Victorian Family*, one of the few historical studies to touch on the experience of dying, focussed on middle- and upper-class dying in the home.<sup>9</sup> The experience of dying in an institution has gone largely unresearched. This is particularly surprising, given how common this experience was. A large-scale, quantitative study of death certificates from the turn of the century has shown that one third of deaths in London in 1900 took place in an institution (workhouses, hospitals or asylums).<sup>10</sup> This section will consider several aspects of dying in the asylum, with a view to casting some light onto the significant historiographic blind-spot of

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<sup>6</sup> Jennifer Wallis, 'Madness Incarnate: The Making of the Patient's Body in Late Nineteenth-Century Asylum Practice', (PhD Thesis, Queen Mary University of London, 2013); Michael Anthony Finn, 'The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century', (PhD Thesis, University of Leeds, 2012); Elizabeth T Hurren, 'Abnormalities and deformities': the dissection and interment of the insane poor, 1832–1929', *History of Psychiatry*, 23 (2012), pp. 65–77.

<sup>7</sup> *History of Psychiatry, Special Issue: Lunacy's Last Rites: Dying insane in Britain, c. 1629–1939*, 23 (2012). Jonathan Andrews' article discusses the practical and special management of the dead in the asylum (though not of the dying), and the meaning of death and post-mortem to patients, families and psychiatrists. Chris Philo and Elizabeth Hurren's contributions both concern the disposal of the asylum's dead, in asylum burial grounds and in University dissection laboratories. Pamela Michael and David Hirst's article primarily concerns funeral rites at Welsh asylums. Leonard Smith, Cathy Smith, Hilary Marland, Jeremy Boulton and John Black all discuss death from insanity: its prevalence and its meaning. Hilary Marland's article does include some discussion of the experience of dying in the asylum, amongst women diagnosed with puerperal insanity. She also examined the women's feelings about death. Marland and Leonard Smith both discuss the experience of dying in the asylum through suicide. There is only one apparent suicide in these case notes, discussed below.

<sup>8</sup> Claire Humphreys, '"Waiting for the Last Summons": The Establishment of the First Hospices in England 1878–1914', *Mortality*, 6 (2010), pp. 148–49.

<sup>9</sup> Patricia Jalland, *Death in the Victorian Family* (Oxford, 1996), pp. 17–189.

<sup>10</sup> Graham Mooney, Bill Luckin and Andrea Tanner, 'Patient Pathways: Solving the Problem of Institutional Mortality in London during the later Nineteenth Century', *Social History of Medicine*, 12 (1999), pp.236–37.

institutional dying. It will look at the way that patients' dying days were narrated in the case notes, and argue that Hanwell's medical officers made substantial (and successful) efforts to shape and control the official narrative of death in the asylum. It will look at the interventions that were made when patients were believed to be dying, drawing on Pat Jalland's contention that palliative care formed a significant part of nineteenth-century medical expertise.<sup>11</sup> Finally, it will consider the role played by families in the death of asylum inmates.

As shown in Figure 6, the majority of patients aged 60 or over at the time of their admission died in the asylum. Over half these patients died within 18 months of their arrival. This suggests that the discourses examined in Chapter Two of this thesis - in which the Lunacy Commissioners, managing committees, and asylum medical officers complained about the phenomenon of moribund, aged patients being sent to the asylum only to die - were not unfounded. My sample contains several examples of patients dying within weeks or days of their admission to Hanwell. Some of these live up to the image of the ailing, harmless, close-to-death senile patient described by the administrators of lunacy in Chapter Two. Ann Allcock was admitted in August 1872, aged 81. The initial entry to her case note, written shortly after her admission, is notably perfunctory: 'She is very aged and imbecile[,] totally unable to do anything for herself and cries and mumbles all day'. She embodied many of the key features of an 'undesirable' asylum case: very old (and therefore probably incurable) dependent, unable to work, and, although 'imbecile', seemingly benign. There is only one further entry to her case note, made three weeks later: 'Is becoming weaker and does not take her food so well. Is wet and dirty in her habits.' Four days later, she died, her death attributed simply to 'senile decay'.<sup>12</sup>

On arrival at the asylum, Ann Allock, and other patients who died quickly, appeared to be far too feeble to pose the kinds of problems of management which

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<sup>11</sup> Jalland, *Death in the Victorian Family*, pp. 78-81.

<sup>12</sup> Ann Allcock, Hanwell Case Book, Female No. 22, H11/HLL/B/19/022 (1872), p. 215; see also Emma Triggall, Hanwell Case Book, Female No. 15, H11/HLL/B/19/038 (1892), p. 91; Maria Johnstone, Hanwell Case Book, Female No. 40, H11/HLL/B/19/063 (1912), p. 137.

usually prompted asylum admittance, as referred to in Chapter Three. Yet their certificates reveal a rather different picture. The certificate of Maria Johnstone – who died a mere two days after her arrival at Hanwell – showed a litany of difficult and unpleasant behaviours. A nurse from Paddington Workhouse claimed that she was ‘very restless and talks incessantly, disturbing the whole ward. She is spiteful when attended to, attempting to bite and scratch. She tried to bit another inmate without provocation’. Cases like this were presumably what erstwhile Hanwell superintendent, Henry Rayner, was referring to when he accused workhouse medical officers of exaggerating the insane behaviour of senile patients, declaring that, ‘It would often be ludicrous, were it not so pitiful, to hear of the dangerous ferocity of a poor decrepit old man, whose limbs will scarcely support him.’<sup>13</sup> Yet, as was discussed in Chapter Three, an inmate did not need to be ‘dangerously ferocious’ in order to present a serious problem for the orderly running of the workhouse. On Ann Allcock’s certificate, the nurse at Kensington Infirmary declared that ‘she screams and shouts for hours at a time, disturbing everybody in the house at a long distance from the ward.’ These women, then, came up against the restrictive institutional norms described in Chapter Two of this thesis: too behaviourally troublesome for the orderly workhouse, but too physically feeble for the asylum.

An asylum patient’s dying days were often the most rigorously documented, after their admission. If an officer or attendant noticed that a patient was showing signs of significant deterioration which indicated proximity to death – such as a particularly violent fit, a high temperature, a diminished appetite, difficulty swallowing, lack of consciousness, a bad cough, or laboured breathing – this observation would be entered into the case book. This was followed by continued observations of the patient’s decline over the subsequent days. The case notes of Mary Ann May, admitted in August 1872 at age 61, are typical in this respect.<sup>14</sup> Her physical health had been unremarkable for most of her stay, but took

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<sup>13</sup> *The Thirty-Third Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1878), pp. 35, 41.

<sup>14</sup> Mary Ann May, H11/HLL/B/19/022 (1872), p. 251.

a sudden turn on 9<sup>th</sup> July 1875. Her case notes were subsequently completed as follows:

July 10. Was taken ill last night at about 11:20. Breathing short and hurried. Pulse quick and weak. Has broncho-pneumonia. Removed to infirmary.

July 11. Much worse. Can scarcely swallow; features dusky; breathing hurried and shallow; expression anxious and distressed; pulse small...

July 12. Rapidly sinking: is moribund.

Cause of death=pleuro-pneumonia

Duration=one week

[signed] J Peeke Richards [Medical Superintendent]

When she was perceived to be showing the signs of serious decline - the shallow breathing, the quick pulse, the darkened skin – Mary Ann was closely watched. Once the doctors were convinced of her imminent demise, the precise nature of her condition ceased to be relevant. It sufficed to record that she was ‘sinking’ and ‘moribund’. In cases where a patient had been ill for some time, the case notes still suggest that the doctors and attendants of Hanwell had a keen sense of when ill health was becoming senescent decline. For example, Harriet Staples, admitted in February 1891 at the age of 78, was put to bed in May of that year, but the doctors did not deem it necessary to begin closely narrating her condition for another month, when she began to ‘complain[] of pain’. They then closely narrated her physical decline and ‘collapsed condition’ over the following weeks until her death.<sup>15</sup>

The confidence with which Hanwell’s doctors were able to determine that a patient was ‘sinking’ should not surprise us. Dying was, in practical terms, one of nineteenth-century medicine’s most developed areas of expertise. As Pat Jalland has argued, late-nineteenth-century medical professionals had extensive training and observational experience, but little access to curative technologies. They therefore ‘compensated for their limited power to cure with a remarkably good record of

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<sup>15</sup> Harriet Staples, Hanwell Case Book, Female No. 13, H11/HLL/B/19/036 (1891), p. 154.

terminal care and palliative management'.<sup>16</sup> Watching people die was a key part of all medical professionals' working lives. Having said this, the role of the nurses and attendants should not be overlooked. In several cases it is made explicit in the case notes that an attendant alerted the medical officers to a patient's critical physical condition. It seems likely that this was the usual sequence of events, in an asylum with well over 1,000 patients and only a handful of doctors. As in the case of Harriet Staples above, it was the nurses – especially those who worked in the infirmary – who were most often present at the point of death and cared for the dying. They had as much intimate experience of death as the asylum's medical officers, if not more.

Of course, sometimes a patient's death caught Hanwell's medical officers by surprise. In these cases, an hour-by-hour, *post-hoc* account of events was recorded in the case notes, instead of the day-to-day entries made during made protracted deaths.<sup>17</sup> Very rarely, a patient would be discovered dead. There is only one such example in my sample, from November 1892, when medical superintendent, R.R. Alexander, came across the body of a patient on one of his regular rounds.<sup>18</sup>

Nov 26. This morning at 11:05, RR Alexander, on going round second infirmary saw [John] Dodge lying on his belly with the back of his head turned upwards, he immediately went in and found Dodge ~~near dead~~ quite dead, no signs of the faintest hearts action being obtainable. Artificial respiration was tried for some time to no avail. The face was rather cyanne the lips full and blue. At 10:40 the attendant had lifted him off a commode and seen him comfortably ensconced in his bed looking the same as past, there being no indication that he was so near death.

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<sup>16</sup> Patricia Jalland, 'Victorian Death and its Decline', in Peter Jupp and Clare Gittings (eds), *Death in England: an illustrated history* (Manchester, 1999), p. 240.

<sup>17</sup> For example, Ann Hart, H11/HLL/B/19/022 (1872), p. 387.

<sup>18</sup> John Dodge, Hanwell Case Book, Male No. 13, H11/HLL/B/20/022 (1892), p. 47.

This example alerts us to the fact that case notes constitute constructed narratives, as much as a straightforward representation of events. The facts of the matter are unclear: was John Dodge 'near dead', or 'quite dead' when Dr Alexander found him? The evidence given – the lack of a pulse, the unsuccessful respiration – suggests that Dodge was dead when he was found, but the presence of the crossed out '~~near dead~~' inserts some ambiguity. The report is written in Dr Alexander's hand, so this textual inconsistency was not a result of miscommunication, but seems instead to be an artefact of the doctor's attempts to construct a coherent narrative of events. The attendant's claim, that there was 'no indication' of Dodge's critical state, suggests a rather questionable sequence of events, in which the patient went from entirely stable to completely dead in a matter of minutes. However, Dr Alexander repeats it as fact, and there is no evidence of disciplinary action being taken against the attendant for dereliction of duty. Dr Alexander's actions and words in the case of John Dodge indicate the Superintendent's desire to provide, in the official record, a contained, uncomplicated narrative of death.

Medical Superintendents had to guard against accusations of mistreatment or neglect of asylum patients, which was a prosecutable offence under the Lunacy Acts. Under the 1862 Lunacy Act, they were required by law to inform the Lunacy Commissioners of any sudden deaths and to inform the county coroner of all deaths.<sup>19</sup> In theory, the coroner could choose to conduct an inquest into any death he deemed suspicious. In practice, according to Pamela Michael and David Hirst, it was often down to the medical officers themselves to draw the attention of the busy coroners to any notable deaths.<sup>20</sup> Inquests were rare at Hanwell. Only one death in my sample ended in an inquest. John Auger was admitted to the asylum on 15<sup>th</sup> December 1871, and died the next day. The inquest returned the verdict that the infirm 79-year-old died of 'natural death from general debility'. The doctor who recorded this verdict into the case book was not satisfied. 'It is represented in the verdict,' he wrote, 'that the death was sudden, whereas the death was not sudden

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<sup>19</sup> Jennifer Wallis, 'The Bones of the Insane', *History of Psychiatry*, 24 (2013), p. 199. This accounts for the dearth of detail regarding patients' deaths in the case notes of 1851-52, compared with the later samples.

<sup>20</sup> Michael and Hirst, 'Recording the Many Faces of Death at the Denbigh Asylum', p. 44.



and no mention of suddenness was made at the inquest.’ He wished it to be made very clear that the death of John Auger was well underway before he arrived, and that his brief time at Hanwell by no means contributed to it.<sup>21</sup>

At Hanwell, it seems, asylum doctors also held the upper hand in determining whether or not an inquest would take place. In this way, they could continue to control the official narrative about a patient’s death, even if there were unusual circumstances or familial concerns. In 1912, a 61-year-old charwoman named Martha Dane was admitted to the asylum, only to die four days later.<sup>22</sup> During this time she reportedly attacked and fought with nurses and other patients, biting and scratching. Before long, she was sent to a padded cell. Each outbreak of violence, along with the response of the officers and attendants, was recounted in detail in the case book. On the morning of her third consecutive day in the padded cell, Martha was found dead. In the case book, the probable cause of death was given as an ‘epileptic seizure’. The subsequent post-mortem, undertaken by one of Hanwell’s assistant medical officers, revealed a ‘mass of soft chewed bread’ at the back of her larynx. Percy Baily, the Medical Superintendent, then gave a second verdict of ‘death from asphyxiation’. He conceded that ‘whether this was suicidal or accidental [he was] unable to say’. These details were all included in the report of Martha’s ‘unusual’ death which Dr Baily sent to the coroner. This report included a brief but dramatic sketch of Martha’s behaviour: ‘She was...brought to the asylum strapped to a stretcher and the Attendant who accompanied her stated that she had been violent...She was subject to frequent attacks of violent frenzy during which she became very excited and fought with and tried to bite those who approached her’. The report continues with an hour-by-hour account of the comings and goings of nurses and doctors to Martha’s cell in the night before her death, and an assurance from one nurse that the intervals between visits had ‘never exceeded half an hour’. The purpose of the report seems to have been to exonerate the asylum and its staff as far as possible; by providing a clear narrative of the appropriate manner in which they fulfilled their duties, and by demonstrating that

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<sup>21</sup> John Auger, Hanwell Case Book, Male No. 11, H11/HLL/B/20/011 (1871), p. 71.

<sup>22</sup> Martha Dane, H11/HLL/B/19/063 (1912), p. 113.

Martha was a truly uncontrollable and unpredictable person. The coroner was perfectly satisfied with Baily's account, agreeing that 'no further light [could] be thrown' on the case by an inquest.

This decision did not satisfy Martha's family. Her brother-in-law wrote a letter to the Commissioners of Lunacy, complaining that 'the explanation given is not at all satisfactory' and that 'it rather looks like something is being hushed up'. They had evidence to bolster their concerns. Martha's sister and sister-in-law, on visiting Martha at the asylum during her brief stay there, had found that some of her lower teeth were missing, and that there was 'a quantity of congealed blood in her mouth'. There was no mention of this in any of the asylum's own records. Her brother-in-law wondered if the same 'rough treatment' which caused this injury might also have caused her death. 'I feel very strongly,' he concluded, 'that anyone who has the misfortune to lose their reason requires all the protection that the law allows.' He was to be disappointed. The Commissioners took no further action beyond forwarding this letter to Hanwell. No inquest was held, and it seems that there was no further communication with the family. Percy Baily clearly felt he had nothing to fear from this challenge, inserting the families' letter – and thus, an alternative version of events – into Martha's case note.

On one hand, Martha Dane's case demonstrates the permeability of the asylum walls. Martha was not abandoned to the asylum; her family came to witness her condition with their own eyes, and felt empowered to bring their concerns after her death to a higher authority. On the other hand, her case also shows how firmly the balance of power was tipped towards the asylum medical staff. Baily used his authoritative position, his role as witness and reporter of events, and his professional relationship with the coroner, to smooth over any irregularities in the story of Martha Dane's death. In the face of outside challenges, which in this case seem to have had some merit, asylum officials were still very successful in controlling the official narrative of deaths which occurred under their jurisdiction.

The case notes offer a good sense of what the doctors and attendants at Hanwell did when they believed a patient was dying. These were not heroic measures. John Dodge's case provides the single example in my sample of an attempt to revive a patient, which seems only to have been attempted because of the apparent suddenness of his death. Once the doctors at Hanwell had judged that a person was 'sinking', they were generally content to observe the patient's inevitable demise. Their observation was not passive: the case notes suggest that the doctors monitored the patients' vital activities: their pulse, their temperature, their breathing. They listened to sounds of their lungs, checking for pneumonia and other respiratory afflictions. The aim of this monitoring, however, appeared to be an assessment of the patient's proximity to death, rather than a precursor to treatment. They had, in the words of one contemporary physician, 'dismiss[ed] all thoughts of cure, or of the prolongation of life'.<sup>23</sup> This statement appeared in a book published in 1887 by a physician named William Munk. It was entitled *Euthanasia*, meaning simply 'a good death'. Munk emphasised that the role of a doctor at the death-bed was to ensure that the patient was as comfortable – physically and mentally – as possible.<sup>24</sup> His attitude was apparently shared by the doctors of Hanwell. They kept the patients nourished, feeding them extra milk and food in liquid form if they could no longer eat solids. The 'appropriate remedies' referred to in the case of Ann Hart probably meant alcohol or 'stimulants'. Although Munk cautioned against the too-liberal use of these, doses of brandy or 'stimulating cough mixture' were the most frequently-administered substances to dying or weak patients at Hanwell. In 1893, an assistant medical officer noted that 82-year-old William Kent was 'being kept alive on milk and brandy, [though] his life is a mere flicker'.<sup>25</sup> When Dalby Scoones' breathing became 'greatly oppressed', he was given 'winetic and tonic medicines' as well as simple 'wine', to no avail.<sup>26</sup> Munk was more enthusiastic about the use of opiates, as a treatment for the physical and

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<sup>23</sup> William Munk, *Euthanasia; or Medical Treatment in Aid of an Easy Death* (London, 1887), p. 86, as quoted in Jalland, 'Victorian Death and its Decline', p. 241.

<sup>24</sup> Jalland, *Death in the Victorian Family*, pp. 82-86; N. Hughes and D. Clark, "'A Thoughtful and Experienced Physician": William Munk and the Care of the Dying in Late Victorian England', *J Palliat Med*, 7 (2004), pp. 703-10.

<sup>25</sup> William Kent, Hanwell Case Book, Male No. 10, H11/HLL/B/20/010 (1871), p. 441.

<sup>26</sup> Dalby Scoones, Hanwell Case Book, Male No. 2, H11/HLL/B/20/002 (1852), p. 236.

mental anguish prior to death. At Hanwell, opium seems to have been used only in cases where the patient was in significant pain from some identifiable source, such as a hernia, or cancer.<sup>27</sup>

Before any of these actions were taken, the patient was usually taken to an infirmary ward, if they were not there already. There are a number of practical reasons for this. The infirmary was, of course, where all patients in need of significant physical care were sent. It had the resources to make the patients more comfortable, such as waterbeds, which were commonly used to prevent and soothe bed-sores. Moving dying patients to the same place also maximised the efficiency of post-mortem procedures, and enabled the swift and unobtrusive removal of patients to the 'dead-house'.<sup>28</sup> The moving of critically ill patients away from the general wards may also have been an act of propriety. Ann Hart's case notes quoted above suggest that the 'appropriate remedies' were administered *prior* to her removal to the infirmary. Her physical needs were provided for on the general ward, and it was only just before her death that she was moved.<sup>29</sup> The removal of dying patients to the infirmary wards allowed Hanwell's staff to minimise the distress of other patients, and to keep death at the asylum spatially contained. If death was contained within the infirmary, the general wards could continue to be viewed as spaces of recovery. In such a large and overcrowded institution, it was important to try to keep the spectre of death as hidden as possible. The removal of dying patients to the infirmary was one way to ensure this.

In the latter part of the nineteenth century, Pat Jalland argues, lay people's priorities regarding death shifted from the spiritual to the physical, and increasing numbers of people sought out medical expertise to ensure as comfortable a death as possible.<sup>30</sup> Jalland's work is based on the interests and behaviour of middle-class families, who could bring a doctor into their home. The growing importance of institutional death, however, can also be understood as part of this wider shift.

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<sup>27</sup> Emma Cecil, H11/HLL/B/19/036 (1891), p. 576; Edward Carwell, H11/HLL/B/20/022 (1892), p. 211.

<sup>28</sup> Jonathan Andrews' discusses the special management of death in the asylum, and the location of the death house, in Andrews, 'Death and the Dead-house in Victorian Asylums', pp. 11-13.

<sup>29</sup> Ann Hart, H11/HLL/B/19/022 (1872), p. 387.

<sup>30</sup> Jalland, *Death in the Victorian Family*, pp. 77, 81-96.

Within the asylum, there were attempts to retain a spiritual presence. Hanwell employed a resident Anglican Chaplain throughout this period, who was joined by a Free Church Minister in the early 1900s.<sup>31</sup> The Chaplain's official duties were to hold services for the patients and make regular rounds of the wards. The Chaplains' annual reports suggest that they tried to minister to the dying, but that this often proved challenging. In his annual report of 1872, Chaplain John May wrote that 'To the dying...my visits are very unsatisfactory'. By the time he was alerted to the fact that a patient was dying, he complained, most were unconscious, and few had the capacity to 'derive benefit from [his] ministrations'.<sup>32</sup> The marginalisation of spiritual ministration to the dying in the asylum, it seems, was less a conscious shift in emphasis, from the spiritual to the medical, and more a result of practical institutional limitations. The institutionalisation of dying necessarily impeded spiritual involvement in death, and put dying people directly in front of medical practitioners. Thus, the nineteenth-century medicalization of death, identified by Pat Jalland, was not just a result of bourgeois fears, and of the rise of medical legitimacy, but a product of the increasing prevalence of institutional death.

Michael and Hirst have suggested that removal to the asylum constituted a 'social death' prior to the patients' actual deaths. The Victorian ideal of a 'good death' involved being surrounded by family, in the home.<sup>33</sup> Having already been removed from their social context, the death of an asylum patient was an institutional event, rather than a familial one. Yet there is evidence from the case notes that patients' families could be involved in the death of their insane relatives. One of the most common ways was through assent to, or refusal of, a post-mortem. Under the 1832 Anatomy Act, institutionalised paupers could legally be 'dissected' for research, teaching or medical investigation. This practice operated under a system of 'presumed consent', but families had the power to refuse permission for

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<sup>31</sup> *The Sixteenth Annual Report of the [LCC] Asylums Committee* (1905), p. 17.

<sup>32</sup> *The Twenty-Seventh Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1872), p. 42.

<sup>33</sup> Jalland, *Death in the Victorian Family*, pp. 26-28. Jalland notes that this ideal was in reality 'more often achieved in Evangelical tracts than in family life', p. 38.

post-mortems to take place.<sup>34</sup> This power, it seems, was rarely used at Hanwell. The Lunacy Commissioners consistently praised the high proportion of deaths at Hanwell which were followed by a post-mortem, and very few case notes in this sample are adorned with the bright red heading 'P.M. refused'. Families and friends could also intervene to provide funeral expenses for patients, and protect them from the fate of a pauper burial. When Esther Racker was admitted to Hanwell in 1892, she was said to have 'no friends known'. Yet, a year later, a friend wrote to say that 'several ladies [were] interested in her case' and that 'she should not be subjected to a post mortem nor have a pauper burial'. They offered up to five pounds towards her funeral expenses.<sup>35</sup>

In 1891-92, the case books contain references to a 'sick note' being sent to families when a patient was seriously ill or seemed close to death. By 1911, this was common practice. This was an important facet of the continued contact between patients, their friends and families and the asylum, reaching far beyond the time of admission. The increased use of the 'sick note' shows that, even while the family voices were becoming marginalised in psychiatric knowledge, their actions, feelings and ideas remained an important influence on asylum practice. When patient Fanny Osborne's breathing became somewhat troubled, the medical officers decided to send a sick note as 'her friends [were] rather fussy' even though they felt that she did 'not appear to be ill'.<sup>36</sup> The sick note gave friends and families the opportunity to visit their relative before they died. There is one case in my sample of a patient's husband being present at her death, even though she had spent nine years in the asylum. Some years earlier, the same patient's husband had asked permission for her to continue to wear her wedding ring, which was granted. He had certainly not considered her 'dead', socially or otherwise, when she entered the asylum.<sup>37</sup> The daughters of another patient, Catherine Johnson, responded to the news of their mother's illness by asking for her to be released to them, so that they might nurse her in her dying days. However, the superintendent judged that 'the

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<sup>34</sup> Andrews, 'Death and the Dead-house in Victorian Asylums', p. 7.

<sup>35</sup> Esther Racker, Hanwell Case Book, Female No. 14, H11/HLL/B/19/037 (1892), p. 457.

<sup>36</sup> Fanny Osborne, Hanwell Case Book, Female No. 39, H11/HLL/B/19/062 (1911), p. 166.

<sup>37</sup> Eliza White, Hanwell Case Book, Female No.40, H11/HLL/B/19/063 (1912), p. 73.

nursing of their mother would throw too great a strain on their health and resources' and the application for discharge was refused.<sup>38</sup> This suggests that the administrators of Hanwell had, by this point, gone some way towards accepting the role of the asylum as a provider of palliative care to the old. At the end of her life, Catherine represented the type of patient many asylum physicians claimed to be loath to treat: infirm, dependent and, 'altogether requir[ing] the greatest care and attention'. Yet when offered relief from this burden, the superintendent and the managing committee chose not to take it. Four weeks later, Catherine died, in the asylum, in the presence of a nurse.

## Discharge

Death was not the only way out of Hanwell for older patients: over a quarter of patients in this sample were discharged, or transferred to another institution. There were three categories of 'discharge' set out under the 1845 Lunacy Act: 'recovered', 'relieved' and 'not improved'.<sup>39</sup> These categories were used at Hanwell, although the nomenclature changed over time: in the 1850s, 'recovery' was sometimes referred to as 'cure', and in the 1850s and 70s 'improved' was used more regularly than 'relieved'. These assigned categories indicate that it was possible for a patient over 60 to recover; or rather, that patients over 60 could be categorised as such. Forty per cent of the patients in this sample who were discharged were said to be recovered. Recovery rates, of course, diminished significantly with age, but older patients could still recover: 11 of the 124 patients who were 70 or over on admission were discharged recovered.

For the most part, however, this tripartite categorisation of patients obscures more than it reveals. The different categories were used inconsistently. The category 'relieved' almost disappeared in the 1910s, replaced by the more ambiguous term 'discharged'. Across this period, patients who were transferred to other asylums might be classified as relieved, or as not improved. Clinically, the lines between all of these categories were blurred. Discharge, just like admission,

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<sup>38</sup> Catherine Johnson, H11/HLL/B/19/063 (1912), p. 88.

<sup>39</sup> *Lunacy Act* (1845), s. 50, Schedule E.

was not decided on purely clinical grounds: it was a process negotiated between the asylum, the family, and the Poor Law Union, taking into account the needs and capacities of each.<sup>40</sup> A more meaningful classification of these discharges, then, would take into account the party which instigated the discharge, and the patient's destination. The rest of this chapter will consider discharges instigated by the medical superintendent, discharges instigated by families and friends, and discharges to other institutions.

The Medical Superintendent had significant power in the discharge process, far more so than in the admissions process. Most of the patients who left the asylum did so because they had been identified as suitable candidates for discharge by the Medical Superintendent. As Mary Fisher has pointed out, the category 'recovered' was reserved entirely for such patients: it was, after all, the professional and legal duty of the Medical Superintendent to release patients who were no longer insane as soon as possible.<sup>41</sup> Unlike newly certified patients, to whom the asylum medical officers had no access prior to their admission, discharged patients were entirely under the purview of the Medical Superintendent's medical judgement. As David Wright puts it, 'identifying patients for discharge was one of the few areas in which medical superintendents could attempt to establish expertise in the new field of mental disease.'<sup>42</sup> They were not, however, the only authority in the discharge process. In legal terms, it was the managing Committee of Visitors who had the most responsibility in deciding if a patient was to be discharged. Under the 1853 Lunatic Asylums Act, a patient could be discharged through the assent of three asylum Visitors, or two Visitors with additional support from the Medical Superintendent.<sup>43</sup> Discharge decisions were made at the monthly meetings of the Hanwell Committee of Visitors prior to 1889, and at the meetings of the LCC

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<sup>40</sup> David Wright, 'The Discharge of Pauper Lunatics from County Asylums in Mid-Victorian England; the Case of Buckinghamshire, 1853-72', in Joseph Melling and Bill Forsythe (eds), *Insanity, Institutions, and Society, 1800-1914* (London, 1999), pp 94-8, and *passim*; Joseph Melling and Bill Forsythe, *The Politics of Madness: the State, Insanity and Society in England, 1845-1914* (London, 2006), pp. 113-4; Mary Fisher, '"Getting Out of the Asylum": Discharge and Decarceration Issues in Asylum History, c1890-1959', (PhD Thesis, University of East Anglia, 2003), pp. 3-4, 29-88.

<sup>41</sup> Fisher, 'Getting Out of the Asylum', p. 137.

<sup>42</sup> Wright, 'The Discharge of Pauper Lunatics from County Asylums in Mid-Victorian England', p. 107; see also Fisher, 'Getting Out of the Asylum', p. 3.

<sup>43</sup> *Lunatic Asylums Act* (1853), 16 & 17 Vict. c. 97 s. 79.



Asylum Committee thereafter. For the most part, this was a simple process, in which the Committee signed off on the recommendations for discharge brought forward by the Superintendent. In some cases, friends or relatives of a patient requested permission to remove them from the asylum on an 'undertaking'. This was a legally prescribed process, which took into account practical and financial considerations, rather than medical ones: undertakings were to be granted only if the asylum Visitors were satisfied that the patient would be properly taken care of, would pose no danger to themselves or others and, crucially, would not be chargeable to the Union upon their release.<sup>44</sup> Legally, the Medical Superintendent had no official role in granting these undertakings; that decision belonged purely to the justices. In practice, it seems, the Medical Superintendent was generally happy to agree to these requests, discharging the patients 'relieved'. Their opinion was not decisive, however, and this sample contains two cases of patients who were discharged on undertaking without the Medical Superintendent's approval.

The clinical criteria for recovery were as ambiguous as the criteria for insanity. In an article in the *Journal of Mental Science*, private asylum physician, Hebert Hayes Newington, suggested that the most important question in deciding a discharge was 'How far has the residence of the patient answered the purpose for which he was sent there?'<sup>45</sup> In the few cases where precise details of a patient's recovery are included in the Hanwell case notes, they were often a reflection of the patient's condition on admission. Patients who had been described as desponding or melancholic on admission were, in their last case note entries, described as bright and cheerful; patients who had been excited were described as calm or quiet; patients who had been incoherent were said to be rational; patients who were delusional or hallucinating had finally realised their errors. In clinical terms, then, recovery was depicted as an amelioration of the most salient aspects of an individual patient's insanity. However, as shown in Chapter Three, the 'purpose for which the patient was sent' was only partially dependent on their clinical state,

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<sup>44</sup> *Lunatic Asylums Act* (1853), 16 & 17 Vict. c. 97, s. 81.

<sup>45</sup> H. Hayes Newington, 'What are the Tests of Fitness for Discharge from Asylums?', *Journal of Mental Science*, 32 (1887), p. 491.

and was predicated on the manageability of their behaviour. Recovered patients were not expected to be fully *compos mentis*, and a certain level of mental enfeeblement was tolerated in supposedly 'recovered' patients'. Prior to his discharge 'recovered' to the workhouse, Thomas Adams' delusions of suspicion had disappeared, but his 'memory remain[ed] very defective'.<sup>46</sup> Catherine Burke had also lost her delusions of suspicion when the medical officers began to consider her discharge, but she was still 'liable to be depressed' and 'timid and apprehensive' at the thought of going home.<sup>47</sup> An imperfect level of recovery, then, was sufficient to be categorised as 'recovered'.

Just as a patient's unmanageability was often key to the decision to institutionalise them, order and quiet were referred to as signs of recovery. Orderly behaviour in the case notes was often aligned to 'industriousness'. A return to productive work had practical and therapeutic implications, for both the individual and the institution. The work performed by patients was essential to the asylum's smooth and economical operation. Hanwell was remarkably self-sufficient, with its own farm and even its own brewery. A patient with specific occupational skills, such as shoemaking and carpentry, would find those skills put to use in the asylum's workshops.<sup>48</sup> Others would work in the garden, the kitchens, the laundry, or at cleaning and maintaining the ward. This work was not confined to younger patients: Richard Chassell was 72 when he entered Hanwell, lauded as a 'hale and hearty old man', and worked as a carpenter during his year of residence there.<sup>49</sup> A return to productive work was a necessity for many patients, and the ability to be self-sufficient was taken into account in discharge decisions. George Stuck was insistent that he could 'easily support [his wife] by hawking', if he was discharged, and so was sent out on trial.<sup>50</sup>

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<sup>46</sup> Thomas Adams, H11/HLL/B/20/021 (1891), p. 321.

<sup>47</sup> Catherine Burke, H11/HLL/B/19/019 (1871), p. 385.

<sup>48</sup> Richard Chessel, H11/HLL/B/20/012 (1872), p. 139; John Willerson, H11/HLL/B/20/012 (1872), p. 37.

<sup>49</sup> Richard Chessel, H11/HLL/B/20/012 (1872), p. 139.

<sup>50</sup> George Stuck, H11/HLL/B/20/039 (1911), p. 150.

At the same time, there was clearly no expectation that all of the discharged patients would support themselves in the outside world. Work at the asylum was understood partly as therapy, 'chiefly regarded as valuable in relation to its salutary influence on the patients themselves'.<sup>51</sup> Many patients were discharged – 'recovered' or otherwise – to the workhouse, including patients whose employment in the asylum was described as a sign of their mental recovery. A return to 'industriousness', then, was not valued purely as an indication that the discharged patient would not be a burden on the rate payer, as historian Lawrence Ray has argued.<sup>52</sup> Industriousness was valued in and of itself, as a sign of orderliness and tractability, and of re-entry into the social body.<sup>53</sup> Notably, being 'quiet', 'orderly' and 'cheerful' appear to have been equally valued traits amongst recovering older patients. As discussed in Chapter Three, many older patients were removed to the asylum because they did not conform to the role of a docile dependent. A quiet, orderly and essentially pleasant old person, even if they were 'simple' and largely unable to care for themselves, did not pose the management problems which led to asylum admission. If a patient underwent such a transformation in the asylum, then the 'purpose for which [they] were sent' had indeed been fulfilled.

The availability of support outside the asylum was crucial to all discharges. As in the case of admission, the 'capacity and willingness' of families, friends or the Poor Law Union to take responsibility for the patient was as important in securing discharge from the asylum as the patient's clinical state.<sup>54</sup> However, the interactions which occurred between the family, the Poor Law and the asylum at the point of discharge were far less well-documented than those which occurred at the point of admission. All the family interactions described here come from the 1911-12

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<sup>51</sup> John Conolly, *The Treatment of the Insane without Mechanical Restraints* (London, 1856), pp. 181, 57-8, 316-7. For the relationship between moral management and work, see Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (New Haven, 1993), pp. 102, 288-9; Anne Digby, *Madness, Morality and Medicine: a Study of the York Retreat, 1796-1914* (Cambridge, 1985), pp. 42-58.

<sup>52</sup> L. J. Ray, 'Models of Madness in Victorian Asylum Practice', *European journal of sociology*, 22 (1981), p. 256.

<sup>53</sup> Michel Foucault, *Madness and Civilization: a History of Insanity in the Age of Reason* (London, 2001), pp. 47-9, 55-6, 235; James H. Mills, *Madness, Cannabis and Colonialism: the 'Native-Only' Lunatic Asylums of British India, 1857-1900* (Basingstoke, 2000), pp. 38-9.

<sup>54</sup> Melling and Forsythe, *The Politics of Madness*, p. 114.

sample. These case notes reveal that the desires and capacities of the family were taken into account in discharge decisions, even when they had not specifically come forward and asked for the patient to be discharged.<sup>55</sup> George Ostick's final case note entry before his discharge states that, as well as being 'much improved', 'his children [were] anxious to have him with them'.<sup>56</sup> When Catherine Thompson was discharged, Superintendent Percy Baily noted that she was 'not in very robust health' and 'rather senile', but that she 'proposed to live with her daughter in the country' and was therefore suitable to be released.<sup>57</sup>

Although the families were clearly involved in the decision to discharge George and Catherine, they were discharged at the behest of the Superintendent, who recommended them to the Committee himself. Families were more directly involved in 'undertakings', in which a friend or family member came forward to take a patient out of the asylum, even if they had not been deemed 'recovered'. These discharges took place throughout the second half of the nineteenth century, and there are examples in the case notes of children, siblings, spouses, and friends undertaking an older asylum patient's care. For the most part, the Superintendent was happy to allow these discharges to take place, and the patients were categorised as 'relieved'. Two patients, both of whom were admitted in 1911, were discharged without Superintendent Percy Baily's approval. These problematic discharges are far more thoroughly documented than the successful ones, and offer an interesting insight into Baily's attitude towards older patients, and his understanding of role of the asylum.

When Mary Ann Vale was discharged three months after her admission, Baily entered his disapproval into her case note:

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<sup>55</sup> Wright, 'The Discharge of Pauper Lunatics from County Asylums in Mid-Victorian England', pp. 97-8.

<sup>56</sup> George Ostick, H11/HLL/B/20/039 (1911), p. 155.

<sup>57</sup> Catherine Thompson, H11/HLL/B/19/062 (1911), p. 164.

Sept 18 [1911]. A friend applied for her discharge on an undertaking today. This I opposed on the grounds that drink was the cause and that more prolonged abstinence would benefit her and also keep her out of prison. The application was successful and she left this afternoon. Not improved.<sup>58</sup>

Prior to her recovery, a different medical officer had noted that she 'worr[ied] a good bit to go home'. This desire, along with the assurances of the friends who sought to fulfil it, apparently carried more weight with the Committee than Baily's concerns about her need for sobriety. Mary Ann's case demonstrates the significant agency of herself and her friends in the face of opposition from the medical authority. Her case also suggests a difference of opinion between the managing committee and the Medical Superintendent over the role of the asylum. Baily clearly held a long-term and reformatory view of what the asylum could offer its patients: his desire to keep Mary Ann in the asylum, in order to keep her away from drink, suggests a belief in a duty of care, as well as a practical desire to prevent readmission. This is despite the fact that she was diagnosed as a case of 'senile dementia', whose 'simple and demented' mental state identified her as the type of case that Medical Superintendents often derided. The managing committee were either swayed by assurances that Mary Ann would be kept away from drink, or they were motivated by more short-term concerns. There was no suggestion in Baily's report that there was any more actively curative treatment of which she could be availed, nor that she was in any way dangerous; there was no legal reason to keep her in the asylum. The undertaking signed by her friends stated that she would not claim poor-relief, thus her removal from the asylum removed her from public assistance entirely. When such considerations won out against Baily's advice, he was able only to register his opposition by categorising her discharge as 'not improved'.

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<sup>58</sup> Mary Ann Vale, H11/HLL/B/19/062 (1911), p. 144.

In the second case of this nature, the clue to Baily's opposition is not found in the case note itself, but in a letter attached to it. The penultimate entry in Sarah Ann Burt's case note paints a picture of a particularly difficult inmate:

Oct 2. Is very obstinate and demented. Tries to get away and wanders all over the place. Needs constant supervision and is wet and dirty in her habits. Is spiteful and excitable.

Five days later, the final entry informs us that '[s]he was discharged not relieved to care of sister at Cheltenham.' Her case note reveals nothing more about the circumstances of her removal, but there is a revealing letter, sent by Sarah Ann's sister, Martha, some time after her discharge. Martha begins by telling Dr Baily that she was 'so sorry I took [Sarah Ann] from under your care'. Soon after her arrival at her sister's home, Sarah Ann 'became so troublesome that the person helping me could not manage her'. Martha called for a doctor, who was of the opinion that Sarah Ann was 'stark raving mad', and arranged for her removal to Gloucester County Asylum. Martha wrote that she was 'verry [sic] penitent' and 'so grieved to think that I have been so much trouble to you to get her under my care'. Mournfully, she explained her motivation for having done so: 'I having no one but her hoped she would get allright and be company for me. I am so lonely and think much of her when I am sitting sewing'.<sup>59</sup>

Sarah Ann Burt's case demonstrates that family assurances could carry significant weight in the eyes of the Committee, even in the face of unequivocal opposition from the Superintendent. It is also a useful reminder that the decision to care for an insane relative was not always entirely selfless. Sarah Ann Burt's sister wanted her with her, to keep her company. This may seem slightly naive, given the doctors' assessment of her mental state, but this is not how her sister saw her. Sarah Ann Burt's sister did not see her as a lunatic, or an asylum patient, but as a person, a loved one and a companion. She, and perhaps other family members who acted in a similar way, was not only removing her sister from the asylum, but also seeking to re-establish her identity as someone who was more than a 'patient'.

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<sup>59</sup> Sarah Ann Burt, H11/HLL/B/19/062 (1911), p. 65.

Sarah Ann Burt's was not the only discharge to go wrong. Other discharges, endorsed by the medical superintendent, resulted in re-admittance. A year after her admission, Dr Baily noted that Emma Haselton's friends were 'anxious to have her home', and so recommended her discharge on trial for four weeks. This was usual practice in cases of discharge initiated by the superintendent. Twelve days later, she was brought back to the asylum 'in a now depressed condition, sleepless, constipated, and quite unable to do anything but groan at her miserable lot.' A year later, an entry to Emma's case note indicated that she was 'always expecting to go home', but that 'her friends don't want her home unless she is quite well after their previous experience'.<sup>60</sup> Discharge was an unpredictable process; neither the doctor nor the friends and families could know how they or the patient would respond. In this instance, it seems that Emma Haselton's friends were expecting her to be convalescent, and were not prepared to take on the responsibility for caring for her in the depths of her illness. She died in the asylum a year later. George Stuck, who had assured the doctors that he could 'easily support [his wife] by hawking' before his discharge on trial, was also readmitted two weeks later. He was 'noisy, excited and incoherent', admitting to 'having been drinking heavily'. Two days later, he died.<sup>61</sup>

These stories of relapse and readmittance undercut the optimism inherent in the idea of discharge from the asylum. Indeed, discharge from the asylum did not necessarily mean a return to the home. Of the 115 patients in this sample who were discharged from Hanwell, at least 30 were transferred to another asylum. Patients who were chargeable to Poor Law Unions outside London were transferred to asylums in their home county. Jewish patients were transferred to Hanwell's sibling institution, Colney Hatch, which was treated as the *de facto* asylum for London's Jewish population, although it was never officially designated as such.<sup>62</sup> Maria Waterman, although 73 and 'in very weak health' on her arrival at Hanwell, was transferred to Colney Hatch 'to be quartered along with the other Pauper

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<sup>60</sup> Emma Haselton, H11/HLL/B/19/063 (1912), p. 98.

<sup>61</sup> George Stuck, H11/HLL/B/20/039 (1911), p. 150.

<sup>62</sup> Carole Reeves, 'Insanity and Nervous Diseases Amongst Jewish Immigrants to the East End of London, 1880 - 1920', (PhD Thesis, University of London, 2001), pp. 30-2.

Jewesses of unsound mind' a year after her admission.<sup>63</sup> The case notes also show that Hanwell's officials also used the MAB imbecile asylums as a place to remove some of their aged and incurable patients, though not as many, perhaps, as they might have hoped. In 1870, soon after the opening of the MAB asylums, the Committee of Visitors reported that they 'look[ed] forward at no distant period, to the removal from this Asylum to the whole of this class of Patients, thus creating a large number of vacancies for recent and severe cases.'<sup>64</sup> By 'this class of patients', they meant incurable, enfeebled and unmanageable patients, many of whom were aged. Eighty-four-year-old Sarah Wilford was discharged within weeks of her admission to Hanwell in January 1871, 'to the workhouse for removal to an imbecile asylum'.<sup>65</sup> Sarah Wilford's swift discharge demonstrates the enthusiasm with which the medical officers and managers of Hanwell embraced the new MAB asylums as a potential source of relief from the burden of aged care. Sarah Wilford was not an isolated case, but her experience was not common. Within this sample, only ten patients were discharged with an explicit intent to remove them to a MAB asylum, although others may eventually have found their way to those institutions. None left Hanwell as swiftly as Sarah: three were at Hanwell for less than six months, but four remained there for over a decade. Leaving Hanwell in this manner, being shuttled in the direction of the MAB imbecile asylums, was in many ways the opposite to being discharged 'recovered'. It was a continuation of the institutional displacements described in Chapter Three. Patients were sent to the MAB asylums not because they were recovering, but because the medical officers of the asylum believed that they never would. Patients removed to the MAB asylums faced a lifetime of institutionalisation, and an institutional death, much as if they had remained at Hanwell.

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<sup>63</sup> Maria Waterman, H11/HLL/B/19/022 (1872), p. 291.

<sup>64</sup> *The Twenty-Fifth Report of the Committee of Visitors of the County Lunatic Asylum at Hanwell* (1870), p. 8.

<sup>65</sup> Sarah Wilford, H11/HLL/B/19/019 (1871), p. 177.



## Conclusion

The older a patient was when they were admitted to Hanwell, the less likely they were to leave. An institutional death was therefore a significant part of the asylum experience of aged patients as a group. Those that did die in the asylum benefitted from the developed palliative expertise of the asylum medical officers, but were denied the trappings of a 'good death': although families were alerted in the case of serious illness (at least, in the early twentieth century), and may have achieved a final visit, there is only one case of a relative being present in the final moment. Religious ministrations were available, but marginalised: an institutional death was a medical event, not a spiritual one.

Yet some aged patients did make it out alive, and a few even went home. The evidence in these case notes suggests that Hanwell's Medical Superintendents were generally happy to see older cases removed from their care, provided they were satisfied that the circumstances into which they were sending the patient would be broadly favourable. They did utilise other institutions – particularly the workhouse and the MAB asylums – as places to offload undesirable cases, but not as much as the rhetoric discussed in Chapter Two would suggest. Indeed, perhaps the most significant finding of this chapter is Percy Baily's resistance to certain discharges, which suggest that he still considered older patients to be his responsibility, and did not seek to remove older cases out of his asylum whenever the opportunity arose. The examples in this chapter show that there was not only a recognition that recovery could take place, even when a person fell ill in their sixties, but also a recognition that even 'senile' cases, in which there was little apparent hope for recovery, could still benefit from asylum care.

## Conclusion

This thesis was originally conceived as a history of senile dementia in the nineteenth century: how it was understood, how it was responded to, and what it was like to suffer from such disorders during this period. What has emerged is something at the same time more complicated and more limited. The object of study became old-age mental disorder, and the variety of ways in which it was categorised and understood became part of the investigation. The institutional and intellectual reference point for this thesis became psychiatry alone: its ideas, its institutions, its patients. Thus, the question became: how was old age-mental disorder understood, categorised and responded to in the theory, policy and practice of psychiatry? This conclusion, then, will take the two sections of this question in turn: understandings and categories, and responses. It will outline the major findings of this thesis in each of these areas, relate these to current scholarship, show the limitations of its findings, and suggest new areas of research. Ultimately, it will show that this thesis – the first substantial study of old age in the context of the asylum and psychiatry – has provided a number of starting points for further study, whilst also offering somewhat of a corrective to particular historical narratives. Its overall argument is this: in the late-nineteenth century, senility became more prominent in psychiatry – as a category of mental disorder, as a type of patient, and as a problematic group within the asylum. Yet this prominence did not yield great benefits for the patients themselves: the senile were a perpetual residuum, a problem to be removed but not to be solved, whose fate – if they did end up in the asylum – was likely to be a well-managed, but ultimately rather isolated, institutional death.

## Understandings and Categories

The conceptual history of old-age mental disorder in the nineteenth century has largely been written from the perspective of the twentieth century, by historians who are primarily interested in the emergence of Alzheimer's disease as a major category of old-age mental disorder in the 1970s. In both critical and celebratory

histories of the emergence of Alzheimer's disease, the narrative presented is one of a shift from confusion to clarity: the replacement of the vague and uncertain categories of 'senility' and 'senile dementia', with the unambiguous disease category of Alzheimer's disease.<sup>1</sup> This thesis has attempted to rescue the understanding of old-age mental disorder in nineteenth-century psychiatry from the condescension of this present-centric historiography, by imbuing it with 'the positive structure of a perception, not the negativity of a confusion'.<sup>2</sup> It has argued that the understandings of old-age mental disorder which developed in nineteenth-century psychiatry were set within, and shaped by, the carefully considered structures of psychiatric knowledge. By the end of the nineteenth century, an understanding of senile dementia had emerged which was predicated on the widely influential model of psycho-physiological dissolution, which tied both senility and dementia to a straightforward material process of disintegration, and a predictable progressive dismantling of the mental faculties. That is not to say that there was no ambiguity surrounding the category of senile dementia, particularly when it came to the question of whether it should be considered natural or pathological. This was not, however, due to the 'confusion' of the psychiatric knowledge in which this category was embedded, but due to the deeper uncertainties surrounding the status of the ageing process and its effects.

With regards to the 'perception' of old-age mental disorder in nineteenth-century psychiatry, this thesis has made one key claim: in the second half of the nineteenth century, the agedness of older, mentally disordered people became more important to the way in which they were categorised by psychiatrists, and the way in which their disorders were understood. It has presented two main pieces of evidence to support that claim. Firstly, the range of senile insanities, described in

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<sup>1</sup> For characterisations of nineteenth-century medical understandings of old-age mental disorder as 'vague' and 'confused', see Thomas Beach, 'The History of Alzheimer's Disease: Three Debates', *Journal of the History of Medicine and Allied Sciences*, 42 (1987), p. 327; Martha Holstein, 'Aging, Culture and the Framing of Alzheimer's Disease', in Peter Whitehouse, Konrad Maurer and Jesse Ballenger (eds), *Concepts of Alzheimer Disease: Biological, Clinical and Cultural Perspectives* (Baltimore, 2000), pp. 159, 162-64.

<sup>2</sup> This phrase is used by Gary Gutting to describe what Foucault's *Madness and Civilization* attempted to do to the understanding of insanity prior to the twentieth century. Gary Gutting, 'Foucault and the History of Madness', in Gary Gutting (ed.), *The Cambridge Companion to Foucault* (Cambridge, 1994), p. 59.

psychiatric classifications, expanded in the second half of the nineteenth century. This is clearly demonstrated in the changing classificatory schemes produced by individual British psychiatrists in their own textbooks and treatises, and collectively by the Statistical Committees of the MPA. From the late 1860s, several different categories of senile insanity appeared in these classifications. Senile mania, melancholia and dementia were the most frequently mentioned, but senile epilepsy, paralysis, imbecility and convulsions also appeared. Thus, senile insanity – the umbrella term for all these forms of insanity – came to be understood as a disorder which could manifest in a wide variety of ways: indeed, through ‘all the varied forms of insanity usually differentiated’.<sup>3</sup> By the same token, this meant that an older person suffering from any mental disorder, manifested through any combination of symptoms, could be classified as ‘senile’. The refraction of senile insanity allowed any type of mental suffering to be attributed to the inevitable degeneration of their ageing body.

The second major piece of evidence supporting this claim – that old age became a more important factor in the classification of mental disorder in later life, and in the description of its sufferers – is the increase in the use of the word ‘senile’ in the patient records of Hanwell asylum in the latter part of the nineteenth century. An older patient admitted to Hanwell in the 1890s was far more likely than a patient admitted in the 1870s to be defined and described *as* old. Between the 1870s and the 1890s, the proportion of older patients who were given a ‘senile’ diagnosis, or whose insanity was attributed to senility, increased dramatically. At the beginning of the twentieth century, a new category of physical condition also emerged in Hanwell’s case books: old patients were now often described as ‘senile’ rather than simply as ‘weak’ or ‘feeble’. Thus, the differentiation of the senile patient, in which older patients and their mental disorders came to be defined as inherently and particularly aged, was manifested in texts produced through the institutional practice of psychiatry in the asylum, as well as in more theoretical textbooks and treatises. The emergence of the senile patient at Hanwell is striking,

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<sup>3</sup> William Bevan Lewis, *A Text-book of Mental Diseases: with Special Reference to the Pathological Aspects of Insanity* (2nd edn, London, 1899), p. 406.

in numerical terms, but this phenomenon demands further investigation to see if it was more widely applicable. In her largely literary study of *The Victorians and Old Age*, Karen Chase makes reference to one Poor Law Union in which aged workhouse inmates were reclassified from 'imbecile' to 'senile' between 1880 and 1890.<sup>4</sup> It would be interesting to know if similar patterns of classification and description are discernable at asylums with a more clearly defined intellectual character: such as Morningside in Edinburgh where Medical Superintendent Thomas Clouston took personal responsibility for the assignation of diagnostic labels to his patients.<sup>5</sup> The Lunacy Commissioners' investigation into old age in all English and Welsh asylums in 1895, in which they identified a 'gradual but continual advance' in the proportion of patients whose mental disorder was attributed to old age, does suggest that the emergence of the senile patient in English and Welsh asylum records was a wider phenomenon.<sup>6</sup>

The emergence of the senile patient in nineteenth-century psychiatry, described in this thesis, echoes a broader narrative within the history of old age: that nineteenth-century medical writers and researchers re-imagined the 'aged body' as a decisively differentiated physical type. Carole Haber has argued that the 'elite clinicians' of the Paris School in the early nineteenth century, who drew a new map of the physical effects of ageing through their detailed examinations of dead bodies, 'formulated a definition of old age that separated it medically from all other age groups'.<sup>7</sup> Stephen Katz has similarly argued that post-mortem investigations of old bodies in the nineteenth century, and the medical texts which arose from them, 'transformed [the aged body] into an inherently separate and inevitably pathological aged subject'.<sup>8</sup> Haber and Katz's conclusions were primarily based on an examination of 'canonical [medical] texts' which focussed specifically on ageing.<sup>9</sup>

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<sup>4</sup> Karen Chase, *The Victorians and Old Age* (Oxford, 2009), pp. 40-41.

<sup>5</sup> Gayle Davis, *The Cruel Madness of Love: Sex, Syphilis and Psychiatry in Scotland, 1880-1930* (Amsterdam, 2008), p. 49.

<sup>6</sup> *The Forty-Ninth Annual Report of the Commissioners in Lunacy to the Lord Chancellor* (1895), pp. 3-4

<sup>7</sup> Carole Haber, *Beyond Sixty-Five: the Dilemma of Old Age in America's Past* (Cambridge, 1983), p. 58

<sup>8</sup> Stephen Katz, *Disciplining Old Age: the Formation of Gerontological Knowledge* (Charlottesville, 1996), p. 8.

<sup>9</sup> Particularly Jean-Martin Charcot, *Leçons Cliniques sue les Maladies des Vieillards et les Maladies Chroniques* (Paris, 1867); George M. Beard, *Legal Responsibility in Old Age* (New York, 1874); and the

This thesis has drawn on a very different set of texts, but it employs the same overarching narrative of the development of modern medical knowledge: that, in the early part of the nineteenth century, pathological signs within the body came to dominate the identification and categorisation of disease, which, at the same time, created a stable and thoroughly embodied aged subject (in medicine, at least). In Chapters One and Four of this thesis, the differentiation of the senile patient in late-nineteenth-century psychiatry was attributed in large part to the attempts of David Skae and other psychiatrists to relate categories of mental disease to underlying pathological processes, and to the consequent reorientation of asylum knowledge practices ‘from listening to looking’.<sup>10</sup> The similarity between the findings of this thesis and those of Haber and Katz is encouraging: it suggests that the differentiation of aged bodies in the nineteenth century was part of a wider shift in medical knowledge, beyond texts which were focussed exclusively on old age or on psychiatry. In Chapter One, it was shown that the major medical models of ageing in nineteenth-century medicine – depletion of vital energy and arteriosclerotic atrophy – were employed by psychiatrists in their understanding of old-age mental deterioration. Work remains to be done, however, to link the psychiatric understandings examined in this thesis to other medical understandings of old age in the same time and place.

A multitude of senile insanities were described and employed by British psychiatrists in the final three decades of the nineteenth century. At the turn of the century, however, the classification and categorisation of senile insanity became more limited. Senile dementia was the only form of senile insanity to appear in the classificatory scheme produced by the MPA Statistical Committee in 1906 and – through the Lunacy Commissioners’ adoption of this scheme as the basis of its legally-enforced standard classificatory codes – it became the only senile diagnostic label used at Hanwell. This thesis has argued that the crystallisation of dementia as the prototype of senility was a product of the way in which both categories became

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work of Ignatz Nascher, particularly *Geriatrics: The Diseases of Old Age and its Treatment* (Philadelphia, 1914).

<sup>10</sup> Richard Hunter and Ida Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum--Friern Hospital 1973: a Medical and Social History* (Folkestone, 1974), p. 184.

more decisively, and precisely, embodied during the latter half of the nineteenth century. The development of the model of the psycho-physiological nervous hierarchy in the mid-nineteenth century, and in particular John Hughlings Jackson's theory of dissolution, drew the categories of senility and dementia closer together. Thus, the language and concepts of the evolutionary nervous hierarchy – and of dissolution and degeneration – shaped and reinforced the idea that both senility and dementia constituted a progressive, material unmaking of a person's mind and body: from the highest and most evolved elements of their humanity, to the lowest, animal, automatic parts of their underlying nature. The role of senility as a metaphor for 'degeneration' – the 'model (or series of models) of decline [which] permeated nineteenth-century feeling [and medicine] with images of decay' – and vice versa, is curiously absent from the historiography of both degeneration and old age.<sup>11</sup> This thesis has argued that ageing and dementia were both imagined as processes of phylogenic retrogression by several late-nineteenth-century psychiatrists, which brought the aged and demented closer to childhood, and closer to our primitive ancestors. This has opened up a significant new line of inquiry. The tripartite analogy of old age, childhood and primitivism is unlikely to have been limited to psychiatric discourses.

At the same time as Hughlings Jackson's model of dissolution was drawing the categories of senility and dementia into a clearly defined, psycho-pathological relationship, asylum medical officers being faced with a seemingly unceasing load of old people disintegrating and dying under their care, sinking into 'helpless and hopeless...senile decay'.<sup>12</sup> The second chapter of this thesis argued that the senile emerged as a residual category in the administrative discourses of lunacy and the

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<sup>11</sup> In an early edited collection on the phenomenon of degeneration, J. Edward Chamberlin refers obliquely to this analogy, but does not discuss it J. Edward Chamberlin, 'Introduction', in J. Edward Chamberlin and Sander L. Gilman (ed.), *Degeneration : the dark side of progress* (New York, 1985), p. ix. This pattern is repeated in other studies of degeneration, such as Sherwood Williams, 'The Rise of a New Degeneration: Decadence and Atavism in Vandover and the Brute', *ELH*, 57 (1990), pp. 709-36. There is no mention of the analogy in the major work on degeneration in Britain, Daniel Pick, *Faces of Degeneration : a European Disorder, c.1848-c.1918* (Cambridge, 1989). In works on old age, Helen Small's study of literary and philosophical accounts of old age contains a discussion of post-Darwinian evolutionary accounts of senescence, but not the impact of Spencerian models of evolution, or the analogy with degeneration. Helen Small, *The Long Life* (Oxford, 2007).

<sup>12</sup> *Minutes of the Metropolitan Asylums Board, Vol. XXXVI* (1902), p. 596.

Poor Law: too disorderly for the workhouse, but too old, dependent and incurable for the asylum. In particular, it suggested that the administrators of lunacy – the Lunacy Commissioners, the managers of Hanwell and Caterham asylums, and Medical Superintendents at asylums across the country – mobilised an exclusionary discourse of senility, in their attempts to legitimate their desire to exclude aged patients from their institutions. A particular understanding of old-age mental disorder emerged in this discourse: as a benign, incurable and *natural* phenomenon, which should not be classed as a form of insanity. Just as it has proved politically expedient, in the twentieth century, for neurologists to define Alzheimer's as a pathological disease, it was expedient to the nineteenth-century administrators of lunacy to define senility as a natural, inevitable part of ageing.<sup>13</sup>

## Responses

Displacement is a running theme in this thesis, and is a term which broadly describes the range of responses to old-age mental disorder which it has examined. These responses were characterised, not by a desire to ameliorate their sufferings of the afflicted, but to mitigate the problems they caused to the people around them. In Chapter Three, it was argued that aged patients were moved from one site of care and management to another – from homes and charitable institutions to the workhouse and the asylum – because they had transcended the capacity and willingness of the people within those sites to manage their behaviour and condition. This is hardly a new insight into the history of the asylum, indeed, it is an argument from which few asylum historians – from Andrew Scull onwards – have truly deviated. As John Walton put it, when it came to asylum admissions, 'what counted was the degree of inconvenience or danger presented by a person's behaviour, and whether anyone was willing to look after him, or capable of

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<sup>13</sup> One further area of psychiatric practice on which this thesis has not touched is the legal assessment of mental capacity. Nineteenth-century psychiatrists were often called to attest to the insanity or sanity of parties in legal cases, including those which asked them to judge to capacity of an older person. This had significant implications for the understanding of senility, and both Henry Maudsley and Crichton Browne dedicated a substantial section of their writings on old age to this matter. Peter Bartlett has set out a method for using legal records to access understandings of insanity, which points to another fruitful area of research in the area of old-age mental disorder. Peter Bartlett, 'Legal Madness in the Nineteenth Century', *Social History of Medicine*, 14 (2001).



controlling him outside an institution'.<sup>14</sup> It is, however, this congruence with the findings of other historians of the asylum which makes this argument significant in the context of this thesis: aged patients, it seems, were admitted to the asylum for essentially the same reasons as people at any age.

At a policy level, however, the (unsuccessful) exclusion of senile patients from county asylums and from the MAB asylums was both predicated on, and reinforcing of, an understanding of senility which differentiated them from the rest of the asylum population. At the same time, the responses imagined and enacted by the administrators of lunacy at an institutional level were also characterised by displacement. Senile patients embodied both of the characteristics of the least desirable type of asylum patient: incurability and physical infirmity. In the 1850s and 60s, the Lunacy Commissioners imagined the creation of intermediate asylum institutions into which these less desirable cases could be siphoned off. However, Caterham and Leavesden Imbecile Asylums, the institutions which partially represented the fruition of these plans, established their own set of desired norms for their ideal population – namely trainability and inexpensive needs – which also excluded aged and infirm patients. Forty years after the Lunacy Commissioners had first imagined their plans for an intermediate asylum – essentially a holding space for undesirable cases – the MAB adopted the same strategy, building Tooting Bec as an institution into which Caterham and Leavesden's undesirable cases could be displaced. Beyond the perpetual siphoning off of senile cases into increasingly cheaper and less 'elaborate' institutions, it became the policy of the administrators of lunacy from the 1860s to accept, and then promote, the workhouse as the most appropriate site of care for the aged mentally-disordered. However, as discussed at the end of Chapter Two, this position was not supported by workhouse medical officers and Poor Law Guardians, who were well aware of the difficulties even very aged and frail mentally-disordered patients could cause on mixed infirmary wards. For the administrators and officers of both the workhouse and the asylum, then, the

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<sup>14</sup> John K. Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-70', in William F. Bynum, Roy Porter and Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Volume II: Institutions and Society* (London, 1985), p. 4.

answer to the question 'Where should [the senile] be accommodated?' was usually: anywhere but here.<sup>15</sup>

In this way, the problem of accommodating senility highlights the limitation of social policy at the end of the nineteenth century. Around the turn of the century, beginning in the early 1880s, Britain was 'something of a cauldron for the production and discussion of ideas about social life, the aims of social policy, and the roles of charity and government'.<sup>16</sup> The aged mentally-disordered intersected with many of the groups targeted by these discussions, but were denied the kind of positive reforms and policy changes which were directed towards these groups. The Royal Commission of the Aged Poor, for example, was focussed on the problem of 'destitution...occasioned by incapacity for work', not on problems relating to infirmity and care. The eventual policy outcome of these discussions, the introduction of the state pension in 1908, was aimed entirely at alleviating poverty, and was designed to be supplemented by additional income, potentially from work. The needs of the aged beyond financial support were not, therefore, a part of the debates and discussions surrounding the aged poor.<sup>17</sup> The congenitally 'idiot', 'imbecile' or 'mentally enfeebled' were also a subject of the 'Social Question'. This was a group which had historically been closely associated with the senile, legally and medically. The category of idiocy also existed in a slightly ambiguous relationship with that of insanity and, as the nineteenth century progressed, the idiot and imbecile were also progressively and more decisively differentiated from the ranks of the insane. Unlike the senile however, the differentiation of the congenitally mentally enfeebled was productive of, and reinforced by, policies, laws and institutions targeted particularly towards their needs and problems, such as

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<sup>15</sup> C. T. Parsons, 'The Difficulty of Dealing with Cases of Senile Insanity: Where are they to be Accommodated?', *The Lancet*, 172 (1908), pp. 1706-7.

<sup>16</sup> John Offer, 'Dead Theorists and Older People: Spencer, Idealist Social Thought and Divergent Prescriptions For Care', *Sociology*, 38 (2004), pp. 890-91.

<sup>17</sup> This assertion is based on a reading, but not a close analysis, of the report and evidence of the Royal Commission of the Aged Poor. There is certainly more work to be done on issues of independence and dependence in the discourses surrounding the problem of the aged poor at the turn of the century.

Idiots Act of 1886.<sup>18</sup> This is because the feeble-minded and mentally deficient were imbued with meanings, and enmeshed within institutions, which had significant implications for the health and well-being of the nation as a whole. They were 'emblematic of broader political fears about social decline' (such as criminality and racial degeneration) 'but also of progressive aspirations for social improvement' (through education).<sup>19</sup> The senile, however, were connected by contemporary commentators to neither the destruction of society, nor its salvation and, as such, were marginalised by Victorian and Edwardian policy-makers.<sup>20</sup>

The case of the aged mentally disordered, then, supports an interpretation of late-nineteenth-century social policy at the end of the nineteenth century as 'limited' and 'restricted'.<sup>21</sup> In many respects, the aged mentally disordered represented the most deserving of the deserving poor: they were incapacitated by a seemingly inevitable physiological decline, and intersected with one of the most comprehensively provided-for groups of paupers – the insane. Yet the intractability of the senile problem made it an unattractive prospect for the fiscally conservative policy makers who continued to dominate in British politics at the turn of the century. As discussed in Chapter Two, cost was a central concern to the administrators of lunacy in their consideration of alternative provision for the senile. As Martin Gorsky has recently argued, health care provision for the aged

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<sup>18</sup> For more on institutions and policies related to idiocy and mental deficiency in the nineteenth and early twentieth centuries, see Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain c.1870-1959* (Oxford, 1998); David Wright, *Mental Disability in Victorian England: the Earlswood Asylum, 1847-1901* (Oxford, 2001); Mark Jackson, *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Later Victorian and Edwardian England* (Manchester, 2000).

<sup>19</sup> Jackson, *The Borderland of Imbecility*, p. 2.

<sup>20</sup> 'Persons who through mental infirmity arising from age...are incapable of managing themselves or their affairs' were originally included in the Mental Deficiency Bill, but were removed from the final Act. R.A. Leach, *The Mental Deficiency Act, 1913, Together With the Regulations and Rules Made Under the Provisions of that Act, The Departmental Circulars, The Elementary (Defective and Epileptic Children) Acts, 1899 and 1914, and Introduction and Annotations* (London, 1914), p. vii.

<sup>21</sup> This interpretation of the early-twentieth century liberal reforms, and the discussions of the 'Social Question' which preceded them, has become particularly popular in the last decade. See Robert F. Haggard, *The Persistence of Victorian Liberalism: the Politics of Social Reform in Britain, 1870-1900* (Westport, 2001); E. P. Hennock, *The Origin of the Welfare State in England and Germany, 1850-1914: Social Policies Compared* (Cambridge, 2007).

continued to be dominated by the 'engrained assumption[] that facilities should be only of a modest or mean standard' well into the twentieth century.<sup>22</sup>

At the same time, the focus on responses to old-age mental disorder from the perspective of psychiatry provides only a limited picture of responses to old-age mental disorder in late-nineteenth- and early-twentieth-century Britain. Within other medical institutions, it seems that similar exclusionary attitudes towards the aged in general prevailed. Aged patients often failed the selection criteria of voluntary hospitals, which prioritised patients who were curable, and could be returned to productive work.<sup>23</sup> As demonstrated by the case of Agnes Ryder, discussed in Chapter Three, charitable homes for the aged poor also had limited tolerance for disruptive and disorderly inmates. Conversely, evidence given before the Royal Commission for the Aged Poor hints at a more positive response to the aged mentally disordered within the structures and institutions of the Poor Law. When questioned about the activities of Poor Law relieving officers with regards to 'very old people...who are suffering from senile dementia', Mr J. H. Thomas, Clerk to the Guardians of the Carnarvon Poor Law Union in North Wales, responded that 'If [the relieving officers] cannot get such people to come into the workhouse, they try to get the neighbours to turn in occasionally to see how they are getting on'.<sup>24</sup> Similarly, the Rev. Canon Hinds Howell, Chairman of the Board of Guardians of a Poor Law Union in Norfolk, suggested that 'if there was anyone to take care of [senile demented] they were left at home, but otherwise they would be brought 'into the [work]house'.<sup>25</sup> This suggests that, in these rural areas at least, officers of the Poor Law played an active role in ensuring the well-being of the elderly mentally disordered. A study of old-age mental disorder which held the Poor Law at its centre, then, may well produce a very different picture of the response to old-age mental disorder in nineteenth-century Britain.

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<sup>22</sup> Martin Gorsky, 'Creating the Poor Law Legacy: Institutional Care for Older People Before the Welfare State', *Contemporary British History*, 26 (2012), p. 457.

<sup>23</sup> Claudia Edwards, 'Age-Based Rationing of Medical Care in Nineteenth-Century England', *Continuity and Change*, 14 (1999), p. 237.

<sup>24</sup> *Report of the Royal Commission on the Aged Poor* (Cd. 7684, 1895) p. 367.

<sup>25</sup> *Ibid.*, p. 408.

The geographic focus on London, though it provided the interesting case study of the Metropolitan Asylums Board, has also limited the applicability of the findings of this thesis. As David Thomson has stressed, London was not representative of the way that the aged poor were dealt with and accommodated in England and Wales generally. In 1891, 1 in 3 aged paupers in England and Wales received indoor relief, but this ratio rose to 1 in 2 in London.<sup>26</sup> A case study of a different part of the England might produce quite a different picture of the care and management of old-age mental disorder. A study focussed on Scotland, in which the practice of 'boarding out' supposedly harmless lunatics into private dwellings and small licenced houses was legally sanctioned and commonly used, may well have revealed a very different model of aged care.<sup>27</sup> Such a study would provide an extra-institutional dimension which is lacking in this thesis. It seems fair to assume that the majority of people who experienced mental deterioration in their old age remained in the home. As shown in Chapter Three, asylum records can offer us some insight into practices of care within the home. Another potential source is personal documents – letters, diaries and memoirs – of sufferers and those around them. This type of material, if it could be identified, would also offer an extra class dimension to the understanding of the care of senility in old age.<sup>28</sup> Senile paupers were responded to as an intractable problem. A study of responses to old-age mental disorder amongst wealthier people might illuminate whether the exclusion of senility described in this thesis was ultimately driven by an economic motivation, to keep poor-rates low, or if it was part of a deeper unease with the problems of old-age mental disorder.

This thesis has argued that nineteenth-century psychiatry – both in theory and in practice – was an important site for the production of understandings of old-

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<sup>26</sup> David Thomson, 'Workhouse to Nursing Home: Residential Care of Elderly People in England Since 1840', *Ageing and Society*, 3 (1983), p. 47.

<sup>27</sup> Harriet Sturdy and William Parry-Jones, 'Outside the Walls of the Asylum: the History of Care in the Community 1750-2000' in Bartlett and Wright (eds), *Outside the Walls of the Asylum: The History of care in the Community* (London, 1999), pp. 86-114.

<sup>28</sup> Robert Southey, the early-nineteenth-century poet who was held up as the archetype of the senile dement in Bucknill and Tuke's *Manual*, and whose mental decline is a feature of many of the memoirs, letters and reminiscences of his illustrious friends, provides one such case study. John Charles Bucknill and Daniel Hack Tuke, *A Manual of Psychological Medicine* (2nd edn, London, 1862), pp. 127-28.

age mental disorder in nineteenth-century Britain. But it was not, of course, the only site in which such understandings were produced. As psychiatrist Thomas Clouston admitted in his 1883 *Clinical Lectures on Mental Diseases*

I am well aware of the imperfect view of the whole senile condition, bodily and mental, that a physician to an asylum is apt to get from seeing the very worst cases only. His picture is filled in with very black shadows. To keep himself right, he must take all opportunities he has of seeing and studying senility outside of an asylum, trying to look at it with a medico-psychological and pathological eye.<sup>29</sup>

The historian, too, must be aware that a focus on the asylum, and on psychiatry, can only give us a partial and ‘imperfect view’ of the understandings of, and responses to, old-age mental disorder in nineteenth-century Britain. Yet ‘to keep [themselves] right’ in the search for understandings of old-age mental disorder beyond psychiatry, the historian is compelled to do the opposite of what Clouston advises, and avoid looking at old-age mental disorder with the ‘objectivist complicity’ (to use Borch-Jacobsen’s term) of the ‘medico-psychological and pathological eye’.<sup>30</sup> This thesis, then, which examines old-age mental disorder through the categories and institutions of psychiatry, is only the first step towards a deeper understanding of what this condition, and this experience, meant to people ‘before Alzheimer’.

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<sup>29</sup> T. S. Clouston, *Clinical Lectures on Mental Diseases* (London, 1883), p. 589.

<sup>30</sup> Mikkel Borch-Jacobsen, *Making Minds and Madness: From Hysteria to Depression* (Cambridge, 2009), p. 1.

## Bibliography

### Parliamentary papers

*Annual Reports of the Commissioners in Lunacy to the Lord Chancellor* (1847-1912)

*Special Report of the Commissioners in Lunacy to the Lord Chancellor on the Alleged Increase of Insanity* (1897)

*First report of the Local Government Board* (1872)

*Report of the Royal Commission on the Aged Poor* (Cd. 7684, 7684-I, 17684-II, 1895)

*Report of the Royal Commission on the Poor Laws and Relief of Distress* (Cd. 4499, 1909)

*Royal Commission on the Care and Control of the Feeble-Minded* (Cd. 4215-4221, i-vii; Report, Cd. 4202, viii, 1908)

### Public General Statutes

8 & 9 Vict. c. 100, *The Lunacy Act* (1845)

16 & 17 Vict. c. 97, *Lunatic Asylums Act* (1853)

30 Vict. c. 6, *The Metropolitan Poor Act* (1867)

53 Vict. c. 5, *The Lunacy Act* (1890)

### Metropolitan Asylums Board (London Metropolitan Archive)

*Minutes of the Metropolitan Asylums Board*, Vols. V-XLIII, 1871-1909  
26.03

|                                      |          |
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| Caterham Sub-Committee Minutes, 1897 | MAB/0260 |
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| Caterham Sub-Committee Minutes, 1897-99 | MAB/0261 |
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| Caterham Sub-Committee Minutes, 1899-1900 | MAB/0262 |
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| Caterham Sub-Committee Minutes, 1900-1 | MAB/0263 |
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### *Caterham*

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| Medical Superintendent's Report Book, 1900-4 | H23/SL/A/01/006 |
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## Hanwell Asylum (London Metropolitan Archive)

*Annual Report[s] of the Committee of Visitors of the County Lunatic Asylum at Hanwell, (1850-1889)*

H11/HLL/A/3A; H11/HLL/A/4; H11/HLL/A/5; H11/HLL/A/6; H11/HLL/A/7;  
H11/HLL/A/8; H11/HLL/A/9; H11/HLL/A/10; H11/HLL/A/11; H11/HLL/A/12;  
H11/HLL/A/13

### Case Books, Female

|                            |                  |
|----------------------------|------------------|
| Case Book no. 5 (1851-52)  | H11/HLL/B/19/004 |
| Case Book no. 19 (1871)    | H11/HLL/B/19/019 |
| Case Book no. 20 (1871)    | H11/HLL/B/19/020 |
| Case Book no. 21 (1871-72) | H11/HLL/B/19/021 |
| Case Book no. 22 (1872)    | H11/HLL/B/19/022 |
| Case Book no. 23 (1872)    | H11/HLL/B/19/023 |
| Case Book no. 13 (1891)    | H11/HLL/B/19/036 |
| Case Book no. 14 (1891-92) | H11/HLL/B/19/037 |
| Case Book no. 15 (1892)    | H11/HLL/B/19/038 |
| Case Book no. 39 (1911-12) | H11/HLL/B/19/062 |
| Case Book no. 40 (1912)    | H11/HLL/B/19/063 |

### Case Books, Male

|                            |                  |
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| Case Book no. 2 (1851-52)  | H11/HLL/B/20/002 |
| Case Book no. 10 (1871)    | H11/HLL/B/20/010 |
| Case Book no. 11 (1871-72) | H11/HLL/B/20/011 |
| Case Book no. 12 (1872)    | H11/HLL/B/20/012 |
| Case Book no. 12 (1891)    | H11/HLL/B/20/021 |
| Case Book no. 13 (1892)    | H11/HLL/B/20/022 |
| Case Book no. 30 (1911)    | H11/HLL/B/20/039 |
| Case Book no. 31 (1911-12) | H11/HLL/B/20/040 |



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| Case Book no. 32 (1912) | H11/HLL/B/20/041 |
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#### Admissions Registers

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| Register of Male Admissions (1839-53)   | H11/HLL/B/04/00  |
| Register of Female Admissions (1839-58) | H11/HLL/B/02/001 |
| Register of Admissions no. 7 (1869-71)  | H11/HLL/B/05/007 |
| Register of Admissions no. 8 (1871-75)  | H11/HLL/B/05/008 |
| Register of Admissions no. 2 (1887-91)  | H11/HLL/B/05/016 |
| Register of Admissions no. 3 (1891-93)  | H11/HLL/B/05/017 |

#### Civil Registers

|                                |                  |
|--------------------------------|------------------|
| Civil Register no. 3 (1909-11) | H11/HLL/B/07/003 |
| Civil Register no. 4 (1911-12) | H11/HLL/B/07/004 |
| Civil Register no. 5 (1912-13) | H11/HLL/B/07/005 |

#### **London County Council (London Metropolitan Archive)**

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| <i>The...Annual Report[s] of the Asylums Committee and Sub-Committees of [various] Asylums (1890-1912)</i> | 26.21 |
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#### **Other (London Metropolitan Archive)**

|   |             |
|---|-------------|
| Correspondence from Government Bodies to Holborn Board of Guardians, 1875 | HOBG 498/12 |
| St. Olave's Union: Minutes, 1881-2  | BBG/049     |

#### **The Bothwick Institute for Archives, York**

|  |         |
|--|---------|
| Medical Coding schedules, sent out by the Commissioners in Lunacy/Board of Control to asylums/mental hospitals | NHS/P12 |
|--|---------|

### Primary Printed

-----'Annual General Meeting of the Medico-Psychological Association', *Journal of Mental Science*, 22 (1876); 487-503

-----'English and Scotch Asylum Reports for 1878', *Journal of Mental Science*, 25 (1879); 279-299

-----'The Lancet Commission On Workhouse Infirmarys', *The Lancet*, 115 (1880); 816-817

-----'Report of Committee on the Statistical Tables of the Medico-Psychological Association', *Journal of Mental Science*, 28 (1882); 463-464

-----'Report of the Thirty-Seventh Annual Meeting of the Medico-Psychological Association', *Journal of Mental Science*, 28 (1882); 437-462

-----'Little Sisters', *All the Year Round*, 33 (1884); 156-159

-----'Caterham Asylum for Imbeciles', *British Medical Journal*, 2 (1886); 220

-----'Notices by the Registrar', *Journal of Mental Science*, 46 (1900); 830

-----'Medico-Psychological Association of Great Britain and Ireland', *Journal of Mental Science*, 47 (1901); 620-623

-----'Adjourned (1904) Annual Meeting', *Journal of Mental Science*, 51 (1905); 733-772

-----'Medico-Psychological Association of Great Britain and Ireland', *Journal of Mental Science*, 52 (1906); 809-838

-----'Medico-Psychological Association. South-Eastern Division', *Journal of Mental Science*, 56 (1910); 557-573

-----'Dr. James Murray Lindsay', *Journal of Mental Science*, 58 (1912); 197

-----'William Bevan-Lewis, M.Sc., M.R.C.S., L.R.C.P.', *Journal of Mental Science*, 76 (1930); 383-388

A., J. T., 'The Middlesex County Lunatic Asylums, and their Reports for 1855 and 1856', *Journal of Mental Science*, 2 (1856); 354-379

Anstie, Francis E., 'On Certain Nervous Affections of Old Persons', *Journal of Mental Science*, 16 (1870); 31-41

Bacon, Mackenzie, 'On the Mis-use of the Term "Softening of the Brain"', *Journal of Mental Science*, 18 (1872); 217-218

Bevan Lewis, William, 'Methods of Preparing, Demonstrating and Examining Cerebral Structure in Health and Disease', *Brain*, 4 (1881); 82-99

-----, 'Cerebral Localisation In Its Relationships To Psychological Medicine', *The British Medical Journal*, 2 (1883); 624-628

-----, *A Text-book of Mental Diseases: with Special Reference to the Pathological Aspects of Insanity* (1st edn, London, 1889)

-----, *A Text-book of Mental Diseases: with Special Reference to the Pathological Aspects of Insanity* (London, 1899)

Blandford, George Fielding, *Insanity and its Treatment: Lectures on the Treatment, Medical and Legal, of Insane Patients* (London, 1871)

Bolton, Joseph Shaw, 'The Functions of the Frontal Lobes', *Brain*, 26 (1903); 215-241

-----, 'Amentia and Dementia: a Clinico-Pathological Study', *Journal of Mental Science*, 51 (1905); 270-340; 507-539; 639-376

-----, 'Amentia and Dementia: a Clinico-Pathological Study', *Journal of Mental Science*, 52 (1906); 1-28; 221-277; 427-290; 711-744

-----, 'Amentia and Dementia: a Clinico-Pathological Study', *Journal of Mental Science*, 53 (1907); 84-121; 423-474

-----, 'Amentia and Dementia: a Clinico-Pathological Study', *Journal of Mental Science*, 54 (1908); 433-472

-----, 'A Contribution to the Localization of Cerebral Function, Based on the Clinico-Pathological Study of Mental Disease', *Brain*, 33 (1910); 26-148

Booth, Charles, *The Aged Poor in England and Wales* (London, 1894)

-----, *Old Age Pensions and the Aged Poor: A Proposal* (London, 1899)

Bucknill, John Charles, 'The Custody of the Insane Poor', *Journal of Mental Science* (April, 1858); 460-72

Bucknill, John Charles and Tuke, Daniel Hack, *A Manual of Psychological Medicine* (London, 1858)

-----, *A Manual of Psychological Medicine* (2nd edn, London, 1862)

-----, *A Manual of Psychological Medicine* (3rd edn, London, 1874)

Burrows, George Man, *Commentaries on the Causes, Forms, Symptoms, and Treatment, Moral and Medical, of Insanity* (London, 1828)

Campbell, Alfred W., 'The Morbid Changes in the Cerebro-Spinal Nervous System of the Aged Insane', *Journal of Mental Science*, 40 (1894); 638-649

-----, 'Histological Studies on the Localisation of Cerebral Function', *Journal of Mental Science*, 50 (1904); 651-662

Canstatt, Karl Friedrich, *Die Krankheiten des Höheren Alters und Ihre Heilung* (Erlangen, 1839)

Clouston, T. S., 'Skae's Classification of Mental Diseases', *Journal of Mental Science*, 21 (1876); 532-550

-----, *Clinical Lectures on Mental Diseases* (1st edn, London, 1883)

-----, 'An Address Delivered At The Opening Of The Section Of Psychology. The Neuroses And Psychoses Of Decadence', *The British Medical Journal*, 2 (1898); 303-306

-----, *Clinical Lectures on Mental Diseases* (5th edn, London, 1898)^

-----, 'The Epochal Insanities', in Allbutt, Thomas Clifford, *A System of Medicine: by many writers. Vol. 8* (London, 1899); 295-309

Conolly, John, 'Clinical Lectures on the Principle Forms of Insanity', *The Lancet*, 46 (1845); 414-418

-----, 'Clinical Lectures on the Principle Forms of Insanity', *The Lancet*, 47 (1846); 171-175; 233-234; 565-568

-----, *The Treatment of the Insane without Mechanical Restraints* (London, 1856)

Copland, James, *A Dictionary of Practical Medicine* (London, 1858)

Crichton Browne, James, 'Clinical Lectures On Mental And Cerebral Diseases: - V. Senile Dementia', *The British Medical Journal*, 1 (1874); 601-603

-----, 'Clinical Lectures On Mental And Cerebral Diseases (Concluded)', *The British Medical Journal*, 1 (1874); 640-643

-----, 'Skae's Classification of Mental Diseases: A Critique', *Journal of Mental Science*, 21 (1875); 339-365

-----, 'On the Weight of the Brain and its Component Parts in the Insane', *Brain*, 2 (1879); 42-67

-----, 'On Old Age', *The British Medical Journal*, 2 (1891); 727-736

Crookshank, F. Graham, 'Some Notes on the Study of Insanity', *Journal of Mental Science*, 52 (1906); 49-62

Donkin, H. Bryan, 'Charles Arthur Mercier: M.D.Lond., F.R.C.P.Lond., F.R.C.S.Eng. B. 1852: D. 1919', *Journal of Mental Science*, 66 (1920); 1-10

Ferrier, David, *The Functions of the Brain* (London, 1876)

Fry, Danby P., *The Lunacy Acts* (London, 1864)

Gilbert, William, 'The Idiot Colony at Caterham', *Good Words*, 13 (1872); 271-277

Greig, James William, Gattie, William H. and Archbold, John Frederick  
*Archbold's Lunacy and Mental Deficiency* (London, 1915)

Hollander, Bernard, 'The Present State of Mental Science: The First of a Series of Papers on the Localisation of Mental Functions in the Brain', *Journal of Mental Science*, 47 (1901); 293-317

Hughlings Jackson, John, 'The Factors of Insanities', *The Medical Press and Circular*, 108 (1894); 18-22

-----, 'Evolution and Dissolution of the Nervous System', in  
Taylor, J., *Selected Writings of John Hughlings Jackson: vol. 2* (London, 1958); 45-75

Humphreys, Noel A., 'The Alleged Increase of Insanity', *Journal of the Royal Statistical Society*, 70 (1907), pp. 218-229

Ireland, William W., 'German Retrospect', *Journal of Mental Science*, 44 (1898); 860-874

Laycock, Thomas, 'On the Naming and Classification of Mental Diseases and Defects', *Journal of Mental Science*, 9 (1863); 153-172

-----, 'Suggestions for Rendering Medico-Mental Science Available to the Better Administration of Justice and the More Effectual Prevention of Lunacy and Crime', *The British Journal of Psychiatry*, 14 (1868); 334-345

-----, *Mind and Brain* (London, 1869)

-----, 'A Chapter on some Organic Laws of Personal and Ancestral Memory', *Journal of Mental Science*, 21 (1875); 155-187

Lindsay, W. Lauder, 'The Family System as Applied to the Treatment of the Chronic Insane', *Journal of Mental Science*, 16 (1871); 497-527

Maclachlan, Daniel, *A Practical Treatise on the Diseases and Infirmities of Advanced Life* (London, 1863)

MacDonald, J. H., 'Anatomical and Clinical Study of the so-called Senile Plaques', *Journal of Mental Science*, 58 (1912); 678-679

Maudsley, Henry, *The Physiology and Pathology of Mind* (London, 1867)

-----, *Responsibility in Mental Disease* (London, 1874)

-----, *Responsibility in Mental Disease* (2nd edn, London, 1876)

-----, 'The Alleged Increase of Insanity', *Journal of Mental Science* (April, 1877); 45-54

-----, *The Pathology of Mind* (2nd edn, London, 1879)

-----, *The Physiology of Mind* (2nd edn, London, 1879)

-----, *The Pathology of Mind* (3rd edn, London, 1895)

-----, *Body and Will: Being an Essay Concerning Will in its Metaphysical, Physiological, & Pathological Aspects* (London, 1883)

McIntosh, W. C., 'On Some of the Varieties of Morbid Impulse and Perverted Instinct', *Journal of Mental Science*, 11 (1866); 512-533

Mercier, A., 'On the Weight of the Brain in the Insane, with Reference to the Hemispheres, Lobes, Brain-Stem, and Cerebellum: Illustrated by Charts', *Journal of Mental Science*, 37 (1891); 207-211

Mercier, Charles Arthur, *Sanity and Insanity* (London, 1895)

-----, *A Text-book of Insanity* (London, 1902)

Mortimer Granville, J., 'Report of The Lancet Commission on Lunatic Asylums', *The Lancet*, 106 (1875); 890-893

-----, 'Report of The Lancet Commission of Lunatic Asylums', *The Lancet*, 107 (1876); 891-893

Munk, William, *Euthanasia; or Medical Treatment in Aid of an Easy Death* (London, 1887)

Newington, H. Hayes, 'What are the Tests of Fitness for Discharge from Asylums?', *Journal of Mental Science*, 32 (1887); 491-500

Parsons, C. T., 'The Difficulty of Dealing with Cases of Senile Insanity: Where are they to be Accommodated?', *The Lancet*, 172 (1908); 1706-1707

-----, 'Senile Dements In London', *The British Medical Journal*, 2 (1908); 1720-1721

Prichard, James Cowles, *A Treatise on Insanity and Other Disorders Affecting the Mind* (London, 1835)

Rayner, Henry, 'The Classification of Insane States in Revised Statistical Tables', *Journal of Mental Science*, 51 (1905); 140-143

-----, 'Mental After-Care', *Journal of Mental Science*, 70 (1924); 358-362

Rhodes, John Milsom, 'The Provision of Suitable Accommodation for the Various Forms of Insanity', *Journal of Mental Science*, 51 (1905); 681-710

Robertson, W. Ford, 'Normal and Pathological Histology of the Nerve-Cell', *Brain*, 22 (1899); 203-327

-----, *A Text-Book of Pathology in Relation to Mental Diseases* (Edinburgh, 1900)

Rodger, M. M., 'Alzheimer's Disease (Senium Præcox). The Report of a Case and Review of Published Cases', *Journal of Mental Science*, 59 (1913); 115-116

Sankey, W. H. O., 'The Pathology of General Paresis', *Journal of Mental Science*, 9 (1864); 467-493

Savage, George H., 'Cases of Senile Insanity, with Remarks', *Journal of Mental Science*, 29 (1883); 231-241

-----, 'An Address Delivered At The Opening Of The Section Of Psychology, At The Annual Meeting Of The British Medical Association In Belfast, July And August, 1884', *The British Medical Journal*, 2 (1884); 239-243

-----, *Insanity and Allied Neuroses: Practical and Clinical* (London, 1884)

Shaw, James, 'Cases Bearing On Cerebral Localisation', *Journal of Mental Science*, 1 (1882); 771-772

Skae, David, 'A Rational and Practical Classification of Insanity', *Journal of Mental Science*, 9 (1863); 309-319

-----, 'The Morisonian Lectures on Insanity for 1873', *Journal of Mental Science*, 20 (1874); 200-211

-----, 'The Morisonian Lectures on Insanity for 1873 - Lecture III', *Journal of Mental Science*, 20 (1874); 1-20

Smith, R. Percy, 'Henry Rayner, M.D.Aberd., M.R.C.P.Edin', *Journal of Mental Science*, 72 (1926); 171-179

Spencer, Herbert, 'Progress: Its law and cause', *Westminster Review*, 67 (1857); 445-565

-----, *First Principles* (London, 1862)

Stengal, Alfred, 'Some Clinical Manifestations, Visceral and General, of Arteriosclerosis', *The British Medical Journal*, 2 (1906); 1010-1012

Stoddart, W. H. B., *Mind and its Disorders: A Text-Book for Students and Practitioners* (London, 1908)

Thurnam, John, 'On the Weight of the Brain, and on the Circumstances affecting it', *Journal of Mental Science*, 12 (1866); 1-43

Toogood, F. S., 'Ten years of Lunacy Treatment in Lewisham Infirmary', *The Lancet*, 168 (1906); 701-706

Tuke, Daniel Hack, 'On the Various forms of mental disorder. 'Dementia'', *Journal of Mental Science*, 3 (1857); 443-464

Tuke, J. Batty, 'A Plea For The Scientific Study Of Insanity', *Journal of Mental Science*, 1 (1891); 1161-1166

Van Oven, Barnard, *On the Decline of Life in Health and Disease: Being an Attempt to Investigate the Causes of Longevity; and the Best Means of Attaining a Healthful Old Age* (London, 1853)

## Secondary Literature

Achenbaum, W. Andrew, *Old Age in the New Land: the American Experience since 1790* (Baltimore, 1978)

-----, *Crossing Frontiers: Gerontology Emerges as a Science* (New York, 1995)

Ackerknecht, Erwin Heinz, *Medicine at the Paris Hospital, 1794-1848* (Baltimore, 1967)

Adair, Richard, Forsythe, Bill and Melling, Joseph, 'A Danger to the Public? Disposing of Pauper Lunatics in Late-Victorian and Edwardian England: Plympton St Mary Union and the Devon County Asylum, 1867-1914', *Medical History*, 42 (1998); 1-25

Alexander, Franz and Selesnick, Sheldon T. (eds), *The History of Psychiatry: an Evaluation of Psychiatric Thought and Practice from Prehistoric Times to the Present* (New York, 1968)

Anderson, Michael, 'Household Structure and the Industrial Revolution: Mid-Nineteenth-Century Preston in Comparative Perspective', in Laslett, Peter and Wall, Richard (eds), *Households and Family in Past Time* (Cambridge, 1972); 215-236

-----, *Approaches to the History of the Western Family, 1500-1914* (London, 1980)

-----, 'Households, Families and Individuals: Some Preliminary Results from the National Sample from the 1851 census of Great Britain', *Continuity and Change*, 3 (1988); 421-438

Andrews, Jonathan, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11 (1998); 255-281

-----, 'Raising the Tone of Asylumdom': Maintaining and Expelling Pauper Lunatics at the Glasgow Royal Asylum in the Nineteenth Century', in Melling, Joseph and Forsythe, Bill (eds), *Insanity, Institutions, and Society, 1800-1914*, (London, 1999); 200-222



-----, 'Introduction: Lunacy's Last Rites', *History of Psychiatry*, 23 (2012); 3-5

-----, 'Death and the Dead-house in Victorian Asylums: Necroscopy Versus Mourning at the Royal Edinburgh Asylum, c. 1832–1901', *History of Psychiatry*, 23 (2012); 6-26

Andrews, Jonathan , Briggs, Asa , Porter, Roy , Tucker, Penny and Waddington, Keir, *The History of Bethlem* (London, 1997)

Andrews, Jonathan and Digby, Anne (eds), *Sex and Seclusion, Class, and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, (Amsterdam, 2004)

Ariès, Philippe, *Centuries of Childhood* (Harmondsworth, 1973)

Augstein, Hannah Franziska, 'J C Prichard's Concept of Moral Insanity: a Medical Theory of the Corruption of Human Nature', *Medical History*, 40 (1996); 311-343

-----, *James Cowles Prichard's Anthropology: Remaking the Science of Man in Early Nineteenth-Century Britain* (Amsterdam, 1999)

Ayers, Gwendoline M., *England's First State Hospitals and the Metropolitan Asylums Board, 1867-1930* (London, 1971)

Bailey, Victor, *'This Rash Act': Suicide Across the Life Cycle in the Victorian City* (Stanford, 1998)

Ball, Michael and Sunderland, David, *An Economic History of London, 1800-1914* (London, 2001)

Ballenger, Jesse, *Self, Senility, and Alzheimer's Disease in Modern America: a History* (Baltimore, 2006)

Barfoot, M., 'David Skae: Resident Asylum Physician; Scientific General Practitioner of Insanity', *Medical History*, 53 (2009); 469-488

Bartlett, Peter, *The Poor Law of Lunacy: the Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London, 1999)

Bartlett, Peter and Wright, David (eds), *Outside the Walls of the Asylum: the History of Care in the Community 1750-2000*, (London, 1999)

Beach, Thomas, 'The History of Alzheimer's Disease: Three Debates', *Journal of the History of Medicine and Allied Sciences*, 42 (1987); 327-349

Benton, Arthur, *Exploring the History of Neuropsychiatry* (Oxford, 2000)

Berg, Marc, 'Practices of Reading and Writing: the Constitutive Role of the Patient Record in Medical Work', *Sociology of Health & Illness*, 18 (1996); 499-524

- Berg, Marc and Bowker, Geoffrey, 'The Multiple Bodies of the Medical Record: Toward a Sociology of an Artifact', *The Sociological Quarterly*, 38 (1997); 513-537
- Berrios, G. E., 'Descriptive Psychopathology: Conceptual and Historical Aspects', *Psychological Medicine*, 14 (1984); 303-313
- , 'Dementia During the Seventeenth and Eighteenth Centuries: a Conceptual History', *Psychological Medicine*, 17 (1987); 829-837
- , 'Memory and the Cognitive Paradigm of Dementia During the Nineteenth-Century: a Conceptual History', in Murray, R. M. and Turner, Trevor (eds), *Lectures on the History of Psychiatry* (London, 1990); 194-211
- , 'Dementia: Clinical section', in Berrios, G. E. and Porter, Roy (eds), *A History of Clinical Psychiatry: the Origin and History of Psychiatric Disorders* (London, 1995); 34-51
- , *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century* (Cambridge, 1996)
- , 'Classic Text No. 37: J. C. Prichard and the Concept of 'Moral Insanity'', *History of Psychiatry*, 10 (1999); 111-116
- , 'Retrospective Diagnosis and its Vicissitudes', *History of Psychiatry*, 24 (2013); 126-128
- Berrios, G. E. and Freeman, Hugh L. (eds), *Alzheimer and the Dementias*, (London, 1991)
- Berrios, G. E. and Porter, Roy (eds), *A History of Clinical Psychiatry: the Origin and History of Psychiatric Disorders*, (London, 1995)
- Beveridge, Allan, 'Thomas Clouston and the Edinburgh School of Psychiatry', in Berrios, G. E. and Freeman, H. L., *150 Years British Psychiatry* (London, 1991); 359-388
- , 'Madness in Victorian Edinburgh: a study of patients admitted to the Royal Edinburgh Asylum under Thomas Clouston, 1873-1908 Part I', *History of Psychiatry*, 6 (1995); 21-54
- Borch-Jacobsen, Mikkel, *Making Minds and Madness: From Hysteria to Depression* (Cambridge, 2009)
- Boulton, Jeremy and Black, John, 'Those, that Die by Reason of their Madness': Dying Insane in London, 1629-1830', *History of Psychiatry*, 23 (2012); 27-39
- Bowler, Peter J., 'The Changing Meaning of "Evolution"', *Journal of the History of Ideas*, 36 (1975); 95-114
- Boyer, George R. and Schmidle, Timothy P., 'Poverty Among the Elderly in Late Victorian England', *The Economic History Review*, 62 (2009); 249-278

Brown, T. E., 'Dance of the Dialectic? Some Reflections (Polemic and Otherwise) on the Present State of Nineteenth-Century Asylum Studies', *Canadian Bulletin of Medical History*, 11 (1994); 267-295

Canguilhem, Georges, *The Normal and the Pathological* (New York, 1989)

Chamberlin, J. Edward and Gilman, Sander L. (eds), *Degeneration: the Dark Side of Progress* (New York, 1985)

Charland, Louis C, 'Science and Morals in the Affective Psychopathology of Philippe Pinel', *History of Psychiatry*, 21 (2010); 38-53

Chase, Karen, *The Victorians and Old Age* (Oxford, 2009)

Cherry, Stephen, *Mental Health Care in Modern England: the Norfolk Lunatic Asylum/St. Andrew's Hospital c.1810-1998* (Suffolk, 2003)

Chesler, Phyllis, *Women and Madness* (Garden City, 1972)

Clark, Anna, *The Struggle for the Breeches: Gender and the Making of the British Working Class* (Berkeley, 1997)

Clark, Michael J., 'The Data of Alienism': Evolutionary Neurology, Physiological Psychology, and the Reconstruction of British Psychiatric Theory, c.1850 -c.1900', (PhD Thesis, University of Oxford, 1982)

-----, 'A Plastic Power Ministering to Organisation': Interpretations of the Mind-Body Relation in Late Nineteenth-Century British Psychiatry', *Psychological Medicine*, 13 (1983); 487-497

-----, 'Morbid Introspection', Unsoundness of Mind, and British Psychological Medicine, c. 1830 - c. 1900', in Bynum, W. F. , Porter, Roy and Shepherd, Michael (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. III* (London, 1988); 71-101

Clarke, Edwin and Jacyna, L. S., *Nineteenth-Century Origins of Neuroscientific Concepts* (Berkeley, 1987)

Cochrane, David, "'Humane, Economical and Medically Wise": the LCC as Administrators of Victorian Lunacy Policy', in Bynum, William F. and Porter, Roy (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. III* (London, 1988); 247-296

Cole, Joshua, 'The Chaos of Particular Facts: Statistics, Medicine and the Social Body in Early Nineteenth-Century France', *History of the Human Sciences*, 7 (1994); 1-27

Cole, Thomas R., *The Journey of Life: a Cultural History of Aging in America* (Cambridge, 1992)

Coleborne, Catharine, 'Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, c. 1880–1910', *Social History of Medicine*, 19 (2006); 425-442

-----, *Reading 'Madness': Gender and Difference in the Colonial Asylum in Victoria, Australia, 1848-1888* (Perth, 2007)

-----, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914* (Basingstoke, 2010)

Cooter, Roger, *The Cultural Meaning of Popular Science: Phrenology and the Organization of Consent in Nineteenth-Century Britain* (Cambridge 1984)

Cordery, Simon, *British Friendly Societies, 1750-1914* (Houndmills, 2003)

Covey, H. C., 'A Return to Infancy: Old Age and the Second Childhood in History', *International Journal Aging Human Development*, 36 (1992); 81-90

Crammer, J. L., *Asylum History: Buckinghamshire County Pauper Lunatic Asylum--St. John's* (London, 1990)

Crammer, J. L., 'English Asylums and English doctors: Where Scull is Wrong', *History of Psychiatry*, 5 (1994); 103-115

Crary, Jonathan, *Suspensions of Perception: Attention, Spectacle, and Modern Culture* (Cambridge, 2001)

Critchley, Macdonald and Critchley, Eileen A., *John Hughlings Jackson: Father of English Neurology* (Oxford, 1998)

Cunningham, Andrew (ed.), *The Laboratory Revolution in Medicine* (Cambridge, 2002)

Daston, L. J., 'British Responses to Psycho-Physiology, 1860--1900', *Isis*, 69 (1978); 192-208

Daunton, Martin (ed.), *Charity, Self-Interest and Welfare in the English Past*, (London, 1996)

Davis, Gayle, *The Cruel Madness of Love: Sex, Syphilis and Psychiatry in Scotland, 1880-1930* (Amsterdam, 2008)

Dewhurst, Kenneth, *Hughlings Jackson on Psychiatry* (Oxford, 1982)

Digby, Anne, *Madness, Morality and Medicine: a Study of the York Retreat, 1796-1914* (Cambridge, 1985)

Doerner, Klaus, *Madmen and the Bourgeoisie: a Social History of Insanity and Psychiatry* (Oxford, 1977)

Doggett, Maeve E., *Marriage, Wife-Beating, and the Law in Victorian England* (Columbia, 1993)

- Dreuil, D. and Boury, D., 'Autour du Vieillissement: le Normal, le Pathologique et le Fragile. Actualité de Georges Canguilhem', *Éthique & Santé*, 7 (2010); 36-41
- Driver, Felix, *Power and Pauperism: the Workhouse System, 1834-1884* (Cambridge, 1993)
- Dwyer, Ellen., *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick, 1987)
- Edwards, Claudia, 'Age-Based Rationing of Medical Care in Nineteenth-Century England', *Continuity and Change*, 14 (1999); 227-265
- Eigen, Joel Peter, *Witnessing Insanity: Madness and Mad-Doctors in the English Court* (New Haven, 1995)
- Ellis, Robert, 'The Asylum, the Poor Law, and a Reassessment of the Four-Shilling Grant: Admissions to the County Asylums of Yorkshire in the Nineteenth Century', *Social History of Medicine*, 19 (2006); 55-71
- Engstrom, Eric, 'Researching Dementia in Imperial Germany: Alois Alzheimer and the Economies of Psychiatric Practice', *Culture, Medicine and Psychiatry*, 31 (2007); 405-413
- Engstrom, Eric, Burgmair, Wolfgang and Weber, Matthias M., 'Emil Kraepelin's 'Self-Assessment': Clinical Autography in Historical Context', *History of Psychiatry*, 13 (2002); 89-98
- Finn, Michael Anthony, 'The West Riding Lunatic Asylum and the Making of the Modern Brain Sciences in the Nineteenth Century', (PhD Thesis, University of Leeds, 2012)
- Finnane, Mark., *Insanity and the Insane in Post-Famine Ireland* (London, 1981)
- Fish, Frank, 'David Skae, M.D., F.R.C.S: Founder of the Edinburgh School of psychiatry', *Medical History*, 9 (1965); 36-53
- Fisher, Mary, '"Getting Out of the Asylum": Discharge and Decarceration Issues in Asylum History, c1890-1959', (PhD Thesis, University of East Anglia, 2003)
- Fleck, Ludwik, *Genesis and Development of a Scientific Fact* (Chicago, 1979)
- Foucault, Michel, *Madness and Civilization: a History of Insanity in the Age of Reason* (London, 1965)
- , *Discipline and Punish: the Birth of the Prison* (New York, 1977)
- , *The Birth of the Clinic: an Archaeology of Medical Perception* (London, 2003)
- Foucault, Michel and Lagrange, Jacques, *Psychiatric Power: Lectures at the Collège de France, 1973-74* (Basingstoke, 2006)

Fox, Patrick J., 'From Senility to Alzheimer's Disease: The Rise of the Alzheimer's Disease Movement', *The Milbank Quarterly*, 67 (1989); 58-102

Fox, Patrick J., 'The Role of the Concept of Alzheimer Disease in the Development of the Alzheimer's Association in the United States', in Whitehouse, Peter, Maurer, Konrad and Ballenger, Jesse (eds), *Concepts of Alzheimer Disease: Biological, Clinical and Cultural Perspectives* (Baltimore, 2000); 209-233

Freeman, H., 'Psychiatry in Britain, c. 1900', *History of Psychiatry*, 21 (2010); 312-324

Gee, Ellen M. and Gutman, Gloria M. (eds), *The Overselling of Population Aging: Apocalyptic Demography, Intergenerational Challenges, and Social Policy*, (Don Mills, 2000)

George, Daniel R., Whitehouse, Peter J. and Ballenger, Jesse, 'The Evolving Classification of Dementia: Placing the DSM-V in a Meaningful Historical and Cultural Context and Pondering the Future of "Alzheimer's"', *Culture, Medicine, and Psychiatry*, 35 (2011); 417-435

Gijswijt-Hofstra, Marijke and Porter, Roy (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam, 2001)

Goffman, Erving, *Asylums; Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, 1961)

Goose, Nigel and Basten, Stuart, 'Almshouse Residency in Nineteenth-Century England: an Interim Report', *Family & Community History*, 12 (2009); 65-76

Gorsky, Martin, 'Friendly Society Health Insurance in Nineteenth-Century England', in Gorsky, Martin and Sheard, Sally (eds), *Financing medicine : the British experience since 1750* (London, 2006); 147-164

Gorsky, Martin, 'Creating the Poor Law Legacy: Institutional Care for Older People Before the Welfare State', *Contemporary British History*, 26 (2012); 441-465

Gosden, P. H. J. H., *Self-help; Voluntary Associations in the Nineteenth Century* (London, 1973)

Gould, Stephen Jay, *Ontogeny and Phylogeny* (Cambridge, 1977)

Green, David R., *Pauper Capital: London and the Poor Law, 1790-1870* (Farnham, 2010)

Gullette, Margaret Morganroth, *Aged by Culture* (Chicago, 2004)

Gutting, Gary, 'Foucault and the History of Madness', in Gutting, Gary (ed.), *The Cambridge Companion to Foucault* (Cambridge, 1994); 47-70

Haber, Carole, *Beyond Sixty-Five: the Dilemma of Old Age in America's Past* (Cambridge, 1983)

-----, 'Geriatrics', in Van Tassel, David D. and Stearns, Peter N. (eds), *Old age in a Bureaucratic Society: the Elderly, the Experts, and the State in American History* (Westport, 1986); 66-84

Hacking, Ian, 'Biopower and the Avalanche of Printed Numbers', *Humanities in Society*, 5 (1982); 279-295

-----, 'Making up People', in Heller, Thomas C., Sosna, Morton and Wellbery, David E. (eds), *Reconstructing Individualism: Autonomy, Individuality and the Self in Western Thought* (Stanford, 1986); 222-236

-----, 'Get Knitting', *London Review of Books*, 27 (2005); 19-21

-----, 'Kinds of People: Moving Targets', *Proceedings of the British Academy*, 151 (2007); 285-318

Hamlett, Jane and Preston, Rebecca, 'A Veritable Palace for the Hard-Working Labourer?' Space, Material Culture and Inmate Experience in London's Rowton Houses, 1892-1918', in Hamlett, Jane, Hoskins, Lesley and Preston, Rebecca (eds), *Residential institutions in Britain, 1725-1970: Inmates and Environments* (London, 2013); 93-107

Hammerton, A. James, *Cruelty and Companionship: Conflict in Nineteenth-Century Married Life* (London, 1992)

Hannaway, Caroline and La Berge, Ann Elizabeth Fowler, *Constructing Paris medicine*, (Amsterdam, 1998)

Hare, E., 'Was Insanity on the Increase? The Fifty-Sixth Maudsley Lecture', *The British Journal of Psychiatry*, 142 (1983); 439-55

Harrington, Anne, *Medicine, Mind, and the Double Brain: a Study in Nineteenth-Century Thought* (Princeton, 1987)

-----, 'Beyond Phrenology: Localization theory in the modern era', in Corsi, Pietro, *The Enchanted Loom: Chapters in the History of Neuroscience* (Oxford, 1991); 207-239^

Harvey, N., 'A Slavish Bowing Down: the Lunacy Commission and the Psychiatric Profession, 1845-60', in Bynum, William. F., Porter, Roy and Shepherd, Michael (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. II* (London, 1985); 98-131

Heath, Kay, *Aging By the Book: the Emergence of Midlife in Victorian Britain* (Albany, 2009)

Hockey, Jenny and James, Allison, 'Back to our Futures: Imaging Second Childhood', in Featherstone, Mike and Wernick, Andrew (eds), *Images of Aging: Cultural Representations of Later Life* (London, 1995); 135-148

Hoeldtke, Robert, 'The History of Associationism and British Medical Psychology', *Medical History*, 11 (1967); 46-65

Hollen Lees, Lynn, 'The Survival of the Unfit: Welfare Policies and Family Maintenance in Nineteenth-Century London', in Mandler, Peter (ed.), *The Uses of Charity: The Poor on Relief in the Nineteenth-Century Metropolis* (Philadelphia, 1990); 68-91

Holstein, Martha, 'Aging, Culture and the Framing of Alzheimer's Disease', in Whitehouse, Peter, Maurer, Konrad and Ballenger, Jesse (eds), *Concepts of Alzheimer Disease: Biological, Clinical and Cultural Perspectives* (Baltimore, 2000); 158-180

Howell, Joel D., *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore, 1996)

Hughes, N. and Clark, D., '"A Thoughtful and Experienced Physician": William Munk and the Care of the Dying in Late Victorian England', *Journal of Palliative Medicine*, 7 (2004); 703-710

Humphreys, Claire, '"Waiting for the Last Summons": The Establishment of the First Hospices in England 1878-1914', *Mortality*, 6 (2010); 166-186

Hunt, E. H., 'Paupers and Pensioners: Past and Present', *Ageing & Society*, 9 (1989); 407-430

Hunter, Richard and Macalpine, Ida, *Psychiatry for the Poor: 1851 Colney Hatch Asylum--Friern Hospital 1973: a Medical and Social History* (Folkestone, 1974)

Hurren, Elizabeth T., *Protesting about Pauperism: Poverty, Politics and Poor Relief in Late-Victorian England, 1870-1900* (Woodbridge, 2007)

-----, '"Abnormalities and Deformities': The Dissection and Interment of the Insane Poor, 1832-1929', *History of Psychiatry*, 23 (2012); 65-77

Isler, Hansruedi, 'Laycock as the Source of Hughlings Jackson's Reflex and Evolutionary Theories', in Rose, F. Clifford (ed.), *A Short History of Neurology: the British Contribution, 1660-1910* (Oxford, 1999); 145-150

Jackson, Mark, *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Later Victorian and Edwardian England* (Manchester, 2000)

Jacyna, L. S., 'The Physiology of Mind, the Unity of Nature, and the Moral Order in Victorian Thought', *The British Journal for the History of Science*, 14 (1981); 109-132



-----, 'Immanence or Transcendence: Theories of Life and Organization in Britain, 1790-1835', *Isis*, 74 (1983); 311-329^

Jalland, Patricia, *Death in the Victorian Family* (Oxford, 1996)

-----, 'Victorian Death and its Decline', in Jupp, Peter and Gittings, Clare (eds), *Death in England: an illustrated history* (Manchester, 1999); 230-255

Jalland, Patricia and Hooper, John (eds), *Women from Birth to Death: the Female Life Cycle in Britain, 1830-1914* (Brighton, 1985)

Johnson, Paul and Thane, Pat, *Old Age from Antiquity to Post-Modernity* (London ; New York, 1998)

Jones, Kathleen, *Lunacy, Law and Conscience, 1744-1845: the Social History of Care of the Insane* (London, 1955)

-----, *Mental Health and Social Policy, 1845-1959* (London, 1960)

Katz, Stephen, *Disciplining Old Age: the Formation of Gerontological Knowledge* (Charlottesville, 1996)

Katz, Stephen. and Peters, K. R., 'Enhancing the Mind? Memory Medicine, Dementia, and the Aging Brain', *Journal of Aging Studies*, 22 (2008); 348-355

Katzman, Robert and Bick, Katherine, 'The Rediscovery of Alzheimer Disease During the 1960s and 70s', in Whitehouse, Peter, Maurer, Konrad and Ballenger, Jesse (eds), *Concepts of Alzheimer Disease: Biological, Clinical and Cultural Perspectives* (Baltimore, 2000); 104-114^

Killen, Andreas, *Berlin Electropolis: Shock, Nerves, and German Modernity* (Berkeley, 2006)

Kitwood, Tom, 'Dementia: Social Section - Part II', in Berrios, G. E. and Porter, Roy (eds), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London, 1995); 63-71

Laing, R.D. *The Divided Self: A Study in Sanity and Madness* (London, 1960)

Laslett, Peter, 'Size and Structure of the Household in England Over Three Centuries', *Population Studies*, 23 (1969); 199-223

-----, *A Fresh Map of Life: the Emergence of the Third Age* (London, 1989)

Lassek, Arthur M., *The Unique Legacy of Doctor Hughlings Jackson* (Springfield, 1970)

Lazenby Craig, Barbara, 'Hospital Records and Record-Keeping, c. 1850-c. 1950, Part I: The Development of Records in Hospitals', *Archivaria*, 29 (1989); 499-524

Leach, R.A., *The Mental Deficiency Act, 1913, Together With the Regulations and Rules Made Under the Provisions of that Act, The Departmental Circulars, The*

*Elementary (Defective and Epileptic Children) Acts, 1899 and 1914, and Introduction and Annotations* (London, 1914)

Leigh, Denis, *The Historical Development of British Psychiatry* (Oxford, 1961)

Long, Vicky, 'Rethinking Post-war Mental Health Care: Industrial Therapy and the Chronic Mental Patient in Britain', *Social History of Medicine*, 26 (2013); 738-758

López Piñero, J. M., 'The Work of John Hughlings Jackson: Part 1', *History of Psychiatry*, 21 (2010); 85-95

Lunbeck, Elizabeth., *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton, 1994)

MacKenzie, Charlotte, *Psychiatry for the Rich: a History of Ticehurst Private Asylum, 1792-1917* (London, 1992)

MacKinnon, Dolly, 'Bodies of Evidence: Dissecting Madness in Nineteenth-century Australia', in Ferber, Sarah and Wilde, Sally (eds), *The Body Divided: Human Beings and Human 'Materials' in Modern Medical History* (Farnham, 2011); 75-108

MacKinnon, Mary, 'Poor Law Policy, Unemployment, and Pauperism', *Explorations in Economic History*, 23 (1986); 299-336

-----, 'English Poor Law Policy and the Crusade Against Outrelief', *Journal of Economic History*, 47 (1987); 603-625

Macnicol, John, *The Politics of Retirement in Britain, 1878-1948* (Cambridge, 1998)

Mangion, Carmen M., 'Faith, Philanthropy and the Aged Poor in Nineteenth-Century England and Wales', *European Review of History*, 19 (2012); 515-530

Mangum, Theresa, 'Growing Old', in Tucker, Herbert F. (ed.), *A Companion to Victorian Literature and Culture* (Malden, 1999); 97-109

-----, 'Little Women: The Aging Female Character in Nineteenth-Century British Literature', in Woodward, Kathleen M. (ed.), *Figuring Age: Women, Bodies, Generations* (Bloomington, 1999); 59-87

Marland, Hilary, 'Uterine Mischief: W.S. Playfair and his Neurasthenic Patients', in Gijswijt-Hofstra, Marijke and Porter, Roy (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam, 2001); 77-96

-----, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke, 2004)

-----, 'Under the Shadow of Maternity: Birth, Death and Puerperal Insanity in Victorian Britain', *History of Psychiatry*, 23 (2012); 78-90

-----, *Health and Girlhood in Britain, 1874-1920* (Houndmills, 2013)

Maurer, Konrad and Maurer, Ulrike, *Alzheimer: the Life of a Physician and the Career of a Disease* (New York, 2003)

McCandless, P., "'Build! build!' the Controversy Over the Care of the Chronically Insane in England, 1855-1870', *Bulletin of the History of Medicine*, 53 (1979); 553-574

Medick, Hans, 'The Proto-Industrial Family Economy: The Structural Function of Household and Family during the Transition from Peasant Society to Industrial Capitalism', *Social History*, 1 (1976); 291-315

Mellet, D. J., 'Bureaucracy and Mental Illness: the Commissioners in Lunacy 1845-90', *Medical History*, 25 (1981); 221-50

-----, *The Prerogative of Asylums: Social, Cultural, and Administrative Aspects of the Institutional Treatment of the Insane in Nineteenth-Century Britain* (New York, 1982)

Melling, Joseph and Forsythe, Bill (eds), *Insanity, Institutions, and Society, 1800-1914*, (London, 1999)

-----, *The Politics of Madness: the State, Insanity and Society in England, 1845-1914* (London, 2006)

Melling, Joseph, Adair, Richard and Forsythe, Bill, "'A Proper Lunatic for Two Years': Pauper Lunatic Children in Victorian and Edwardian England. Child Admissions to the Devon County Asylum, 1845-1914', *Journal of Social History*, 31 (1997); 371-405

-----, 'Families, Communities and the Legal Regulation of Lunacy in Victorian England: Assessments of Crime, Violence and Welfare in Admissions to the Devon Asylum, 1845-1914', in Bartlett, Peter and Wright, David (eds), *Outside the Walls of the Asylum: the History of Care in the Community 1750-2000* (London, 1999); 153-180

Melling, Joseph and Turner, Robert, 'The Road to the Asylum: Institutions, Distance and the Administration of Pauper Lunacy in Devon, 1845-1914', *Journal of Historical Geography*, 25 (1999); 298-333

Michael, Pamela, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000* (Cardiff, 2003)

Michael, Pamela and Hirst, David, 'Recording the Many Faces of Death at the Denbigh Asylum, 1848-1938', *History of Psychiatry*, 23 (2012); 40-51

Miller, Edgar, 'Variations in the Official Prevalence and Disposal of the Insane in England Under the Poor Law, 1850-1900', *History of Psychiatry*, 18 (2007); 25-38

Mills, James, 'The Mad and the Past: Retrospective Diagnosis, Post-Coloniality, Discourse Analysis and the Asylum Archive', *Journal of Medical Humanities*, 21 (2000); 141-158

-----, *Madness, Cannabis and Colonialism: the 'Native-Only' Lunatic Asylums of British India, 1857-1900* (Basingstoke, 2000)

Montigny, Edgar-André, "'Foisted Upon the Government": Institutions and the Impact of Public Policy Upon the Aged. The Elderly Patients of Rockwood Asylum, 1866-1906', *Journal of Social History*, 28 (1995); 819-836

Mooney, Graham, Luckin, Bill and Tanner, Andrea, 'Patient Pathways: Solving the Problem of Institutional Mortality in London during the later Nineteenth Century', *Social History of Medicine*, 12 (1999); 227-269

Moreira, Tiago, May, Carl and Bond, John, 'Regulatory Objectivity in Action: Mild Cognitive Impairment and the Collective Production of Uncertainty', *Social Studies of Science*, 39 (2009); 665-690

Morgan, D. H. J., *The Family, Politics, and Social Theory* (London, 1985)

Moscucci, Ornella, *The Science of Woman: Gynaecology and Gender in England, 1800-1929* (Cambridge, 1990)

Mullan, Phil, *The Imaginary Time Bomb: Why an Ageing Population is Not a Social Problem* (London, 2002)

Murphy, Elaine, 'The Lunacy Commissioners and the East London Guardians, 1845-1867', *Medical History*, 46 (2002); 495-524

-----, 'A Mad House Transformed: The Lives and Work of Charles James Beverley FRS (1788-1868) and John Warburton FRS (1795-1847)', *Notes and Records*, 58 (2004); 261-281

Neve, Michael and Turner, Trevor H., 'What the Doctor Thought and Did: Sir James Crichton-Browne (1840-1938)', *Medical History*, 39 (1995); 399-432

Offer, John, 'Dead Theorists and Older People: Spencer, Idealist Social Thought and Divergent Prescriptions For Care', *Sociology*, 38 (2004); 891-908

Oppenheim, Janet, *Shattered Nerves: Doctors, Patients, and Depression in Victorian England* (New York, 1991)

Oren, Laura, 'The Welfare of Women in Labouring Families: England, 1860-1950', in Banner, Lois and Hartmann, Mary Susan (eds), *Clio's Consciousness Raised: New Perspectives on the History of Women* (New York, 1976); 226-244

Otis, Laura, 'Organic Memory and Psychoanalysis', *History of Psychiatry*, 4 (1993); 349-372

-----, *Organic Memory: History and the Body in the Late Nineteenth and Early Twentieth Centuries* (Lincoln, 1994)

- Ottaway, Susannah R., *The Decline of Life: Old Age in Eighteenth-Century England* (Cambridge, 2004)
- Packham, Catherine, *Eighteenth-Century Vitalism: Bodies, Culture, Politics* (Houndmills, 2012)
- Parry-Jones, William, *The Trade in Lunacy: a Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London, 1972)
- Pelling, Margaret and Smith, Richard M. (eds), *Life, Death and the Elderly: Historical Perspectives* (London, 1991)
- Philo, Chris, 'Troubled Proximities: Asylums and Cemeteries in Nineteenth-Century England', *History of Psychiatry*, 23 (2012); 91-103
- Pick, Daniel, *Faces of Degeneration: a European Disorder, c.1848-c.1918* (Cambridge, 1989)
- Porter, Roy, 'Madness and Society in England: The Historiography Reconsidered', *Studies in History*, 3 (1987); 275-90
- , *Mind-Forg'd Manacles: a History of Madness in England from the Restoration to the Regency* (London, 1987)
- , 'Foucault's Great Confinement', *History of the Human Sciences*, 3 (1990); 47-54
- , 'History of Psychiatry in Britain', *History of Psychiatry*, 2 (1991); 271-279
- , 'Dementia: Social Section - Part I', in Berrios, G. E. and Porter, Roy (eds), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London, 1995); 52-63
- Porter, Roy and Wright, David (eds), *The Confinement of the Insane: International Perspectives, 1800-1965* (Cambridge, 2011)
- Pugh, Martin, 'Working-Class Experience and State Social Welfare, 1908-1914: Old Age Pensions Reconsidered', *The Historical Journal*, 45 (2002); 775-796
- Rabinbach, Anson, *The Human Motor: Energy, Fatigue, and the Origins of Modernity* (New York, 1990)
- Ray, L. J., 'Models of Madness in Victorian Asylum Practice', *European Journal of Sociology*, 22 (1981); 229-264
- Razi, Zvi, 'The Myth of the Immutable English Family', *Past & Present*, 140 (1993); 3-44
- Reay, Barry, 'Kinship and the Neighborhood in Nineteenth-Century England: the Myth of the Autonomous Nuclear Family', *Journal of Family History*, 21 (1996); 87-104

Reeves, Carole, 'Insanity and Nervous Diseases Amongst Jewish Immigrants to the East End of London, 1880 - 1920', (PhD Thesis, University of London, 2001)

Reinarz, Jonathan and Schwarz, Leonard, *Medicine and the Workhouse* (Rochester, 2013)

Risse, Guenter B. and Warner, John Harley, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, 5 (1992); 183-205

Roebuck, Janet, 'When Does "Old Age" Begin?: The Evolution of the English Definition', *Journal of Social History*, 12 (1979); 416-428

Rose, Nikolas, 'Calculable Minds and Manageable Individuals', *History of the Human Sciences*, 1 (1988); 179-200

-----, 'Of Madness Itself: Histoire de la Folie and the Object of Psychiatric History', in Arthur Still and Irving Velody (eds), *Rewriting the History of Madness: Studies in Foucault's Histoire de la Folie* (London, 1992); 142-149

Ross, Ellen, '"Fierce Questions and Taunts": Married Life in Working-Class London, 1870-1914', *Feminist Studies*, 8 (1982); 575-602

-----, 'Survival Networks: Women's Neighbourhood Sharing in London before World War I', *History Workshop Journal*, (1983); 4-27

Rothman, David J., *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston, 1971)

Ruggles, Steven, *Prolonged Connections: the Rise of the Extended Family in Nineteenth-Century England and America* (Madison, 1987)

Rylance, Rick, *Victorian Psychology and British Culture, 1850-1880* (Oxford, 2000)

Sabean, David Warren, Teuscher, Simon and Mathieu, Jon, *Kinship in Europe: Approaches to Long-Term Developments (1300-1900)* (New York, 2007)

Schaefer, Daniel, *Old Age and Disease in Early Modern Medicine* (London, 2010)

Scott, Joan and Tilly, Louise, 'Women's Work and the Family in Nineteenth-Century Europe', in Rosenberg, Charles E., *The Family in History* (Philadelphia, 1975); 145-178

Scull, Andrew, *Museums of Madness: the Social Organization of Insanity in Nineteenth-Century England* (New York, 1979)

-----, 'A Convenient Place to Get Rid of Inconvenient People: the Victorian Lunatic Asylum', in King, Anthony D., *Buildings and Society: Essays on the Social Development of the Built Environment* (London, 1980); 37-60

-----, 'Was Insanity Increasing? A Response to Edward Hare', *The British Journal of Psychiatry*, 144 (1984); 432-436

-----, 'John Conolly: a Victorian Psychiatric Career', in Scull, Andrew (ed.), *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (London, 1989); 162-213

-----, 'Psychiatry and its Historians', *History of Psychiatry*, 2 (1991); 239-250

-----, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (New Haven, 1993)

-----, 'Psychiatrists and Historical 'Facts'. Part One: The Historiography of Somatic Treatments', *History of Psychiatry*, 6 (1995); 225-241

-----, 'Psychiatrists and Historical 'Facts' Part Two: Re-writing the History of Asylumdom', *History of Psychiatry*, 6 (1995); 387-394

Scull, Andrew, MacKenzie, Charlotte and Hervey, Nicholas (eds), *Masters of Bedlam: the Transformation of the Mad-Doctoring Trade* (Princeton, 1996)

Shahar, Shulamith, *Growing Old in the Middle Ages: 'Winter Clothes us in Shadow and Pain'* (London, 2004)

Shepherd, Anne, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', in Andrews, Jonathan and Digby, Anne (eds), *Sex and Seclusion, Class, and Custody : Perspectives on Gender and Class in the History of British and Irish psychiatry* (Amsterdam, 2004); 223-248

-----, 'Mental health Care and Charity for the Middling Sort: Holloway Sanatorium 1885-1900', in Borsay, Anne and Shapely, Peter (eds), *Medicine, Charity and Mutual Aid: the Consumption of Health and Welfare in Britain, c.1550-1950* (Aldershot, 2007); 163-182

Shorter, Edward, *A History of Psychiatry: from the Era of the Asylum to the Age of Prozac* (New York, 1997)

Showalter, Elaine, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (New York, 1985)

Shuttleworth, Sally, *The Mind of the Child: Child Development in Literature, Science and Medicine, 1840-1900* (Oxford, 2010)

Skultans, Vieda, *English Madness: Ideas on Insanity, 1580-1890* (London, 1979)

Small, Helen, 'In the Guise of Science': Literature and the Rhetoric of Nineteenth-Century English Psychiatry', *History of the Human Sciences*, 7 (1994); 27-55

Small, Helen, 'The Unquiet limit: Old Age and Memory in Victorian Narrative', in Campbell, Matthew, Labbe, Jacqueline and Shuttleworth, Sally (eds), *Memory and Memorials, 1789-1914: Literary and Cultural Perspectives* (London, 2000); 60-79

Small, Helen, *The Long Life* (Oxford, 2007)

Smith, Cathy, 'Living with Poverty: Narratives of Poverty, Pauperism and Sickness in Asylum Records 1840-1876', in Gestrich, Andreas, Hurren, Elizabeth and King, Steven (eds), *Poverty and Sickness in Modern Europe: Narratives of the Sick Poor, 1780-1938* (London, 2012); 117-142

-----, 'Visitation by God': Rationalizing Death in the Victorian Asylum', *History of Psychiatry*, 23 (2012); 104-116

Smith, C. U. M., 'Evolution and the Problem of Mind: Part I. Herbert Spencer', *Journal of the History of Biology*, 15 (1982); 55-88

-----, 'Evolution and the Problem of Mind: Part II. John Hughlings Jackson', *Journal of the History of Biology*, 15 (1982); 241-262

Smith, Leonard, *Cure, Comfort, and Safe Custody: Public Lunatic Asylums in Early Nineteenth Century England* (London, 1999)

-----, 'Your Very Thankful Inmate': Discovering the Patients of an Early County Lunatic Asylum', *Social History of Medicine*, 21 (2008); 237-252

-----, 'Welcome Release: Perspectives on Death in the Early County Lunatic asylums, 1810-50', *History of Psychiatry*, 23 (2012); 117-128^

Smith, Richard, 'Charity, Self-Interest and Welfare: Reflections from Demographic and Family History', in Dauntton, Martin (ed.), *Charity, Self-Interest and Welfare in the English Past* (London, 1996); 194-221

-----, 'Ageing and Well-Being in Early Modern England: Pension Trends and Gender Preferences Under the English Old Poor Law c. 1650-1800', in Johnson, Paul and Thane, Pat (eds), *Old Age from Antiquity to Post-Modernity* (London, 1998); 64-95

Star, Susan Leigh, *Regions of the Mind: Brain Research and the Quest for Scientific Certainty* (Stanford, 1989)

Stearns, Peter N., 'Old Women: Some Historical Observations', *Journal of Family History*, 5 (1980); 44-57

Stearns, Peter N., 'Working-Class Women in Britain, 1890-1914', in Vicinus, Martha (ed.), *Suffer and be Still: Women in the Victorian Age* (Bloomington, 1973); 401-424^

Stearns, Peter N., *Old age in European Society: the Case of France* (London, 1977)

Stedman Jones, Gareth, *Outcast London: a Study in the Relationship Between Classes in Victorian Society* (Oxford, 1971)

Still, Arthur and Velody, Irving (eds), *Rewriting the History of Madness: Studies in Foucault's Histoire de la Folie*, (London, 1992)



Stone, Lawrence, *The Family, Sex and Marriage in England, 1500-1800* (New York, 1977)

Straley, Jessica, 'Of Beasts and Boys: Kingsley, Spencer and the Theory of Recapitulation', *Victorian Studies*, 49 (2007); 583-609

Sturdy, Harriet and Parry-Jones, William, 'Boarding-Out Insane Patients: the Significance of the Scottish System 1857-1913', in Bartlett, Peter and Wright, David, *Outside the Walls of the Asylum: the History of Care in the Community 1750-2000* (London, 1999); 86-114

Suzuki, Akihito, 'The Politics and Ideology of Non-Restraint: The Case of the Hanwell Asylum', *Medical History*, 39 (1995); 1-17

-----, 'Framing Psychiatric Subjectivity: Doctor, Patient and Record-Keeping in the Nineteenth Century', in Melling, Joseph and Forsythe, Bill (eds), *Insanity, institutions, and society, 1800-1914* (London, 1999); 115-136

-----, *Madness at Home: the Psychiatrist, the Patient, and the Family in England, 1820-1860* (Berkeley, 2006)

-----, 'Lunacy and Labouring men: Narratives of Male Vulnerability in Mid-Victorian London', in Bivins, Roberta E. and Pickstone, John V. (eds), *Medicine, Madness, and Social History: Essays in Honour of Roy Porter* (Basingstoke, 2007); 118-128

Swartz, Sally, 'Changing Diagnoses in Valkenberg Asylum, Cape Colony, 1891-1920: a Longitudinal View', *History of Psychiatry*, 6 (1995); 431-451

Szasz, Thomas, 'The Myth of Mental Illness', *The American Psychologist*, 16 (1960); 113-118

-----, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York, 1961)

Taylor, Steven J., 'All his Ways are That of an Idiot': the Admission, Treatment of and Social Reaction to Two 'Idiot' Children of the Northampton Pauper Lunatic Asylum', *Family & Community History*, 15 (2012); 34-43

Thane, Pat, 'Old People and their Families in the English Past', in Daunton, Martin (ed.), *Charity, Self-Interest and Welfare in the English Past* (London, 1996); 113-138

-----, *Old Age in English History: Past Experiences, Present Issues* (Oxford, 2000)

-----, 'Social Histories of Old Age and Aging', *Journal of Social History*, 37 (2003); 93-111

Thomson, David, 'Workhouse to Nursing Home: Residential Care of Elderly People in England Since 1840', *Ageing and Society*, 3 (1983); 43-69

-----, 'I Am Not my Father's Keeper': Families and the Elderly in Nineteenth-Century England', *Law and History Review*, 2 (1984); 265-286

-----, 'The Decline of Social Welfare: Falling State Support for the Elderly Since Early Victorian Times', *Ageing & Society*, 4 (1984); 451-482

-----, 'The Welfare of the Elderly in the Past: a Family or Community Responsibility?', in Pelling, Margaret and Smith, Richard (eds), *Life, Death and the Elderly* (London, 1994); 161-182

Thomson, Mathew, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain c.1870-1959* (Oxford, 1998)

Tomes, Nancy, 'A "Torrent of Abuse": Crimes of Violence between Working-Class Men and Women in London, 1840-1875', *Journal of Social History*, 11 (1978); 328-345

-----, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883* (Cambridge, 1984)

-----, 'The Great Restraint Controversy: a Comparative Perspective on Anglo-American Psychiatry in the Nineteenth Century', in Bynum, William F. and Porter, Roy (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. III* (London, 1988); 190-225

-----, 'Feminist Histories of Psychiatry', in Micale, Mark S. and Porter, Roy, *Discovering the History of Psychiatry* (Oxford, 1994); 348-343

Townsend, Peter, 'The Structured Dependency of the Elderly: A Creation of Social Policy in the Twentieth Century', *Ageing & Society*, 1 (1981); 5-28

Troyansky, David G., *Old Age in the Old Regime: Image and Experience in Eighteenth-Century France* (Ithaca, 1989)

von Kondratowitz, Hans-Joachim, 'The Medicalization of Old Age: Continuity and Change in Germany from the Late-Eighteenth to the Early Twentieth Century', in Pelling, Margaret and Smith, Richard (eds), *Life, Death and the Elderly* (London, 1994); 112-137

Vrettos, Athena, *Somatic Fictions: Imagining Illness in Victorian Culture* (Stanford, 1995)

Wall, Richard, 'Elderly Persons and Members of their Households in England and Wales from Preindustrial Times to the Present', in Kertzer, David and Laslett, Peter (eds), *Aging in the Past: Demography, Society and Old Age* (Berkeley, 1995); 81-106

-----, 'Elderly Widows and Widowers and their Coresidents in Late Nineteenth- and Early-Twentieth-Century England and Wales', *The History of the Family*, 7 (2002); 139-155

Wallis, Jennifer, 'The Bones of the Insane', *History of Psychiatry*, 24 (2013); 196-211

-----, 'Madness Incarnate: The Making of the Patient's Body in Late Nineteenth-Century Asylum Practice', (PhD Thesis, Queen Mary University of London, 2013)

Walton, John K., 'Lunacy in the Industrial Revolution: A Study of Asylum Admissions in Lancashire, 1848-50', *Journal of Social History*, 13 (1979); 1-22

-----, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840-70', in Bynum, William F., Porter, Roy and Shepherd, Michael (eds), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. II* (London, 1985); 132-146

Wannell, Louise, 'Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910', *Social History of Medicine*, 20 (2007); 297-313

Warren, Howard C., *A History of the Association Psychology* (New York, 1921)

Watson, William, 'Psychiatry as Craft', *History of Psychiatry*, 9 (1998); 355-381

Whitehouse, Peter J., Maurer, Konrad and Ballenger, Jesse F. (eds), *Concepts of Alzheimer Disease: Biological, Clinical, and Cultural Perspectives*, (Baltimore, 2000)

Wise, Sarah, *Inconvenient People: Lunacy, Liberty and the Mad-Doctors in Victorian England* (London, 2012)

Wright, David, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine*, 10 (1997); 137-155

-----, 'The Certification of Insanity in Nineteenth-Century England and Wales', *History of Psychiatry*, 9 (1998); 267-290

-----, 'The Discharge of Pauper Lunatics from County Asylums in Mid-Victorian England; the Case of Buckinghamshire, 1853-72', in Melling, Joseph. and Forsythe, Bill. (eds), *Insanity, Institutions, and Society, 1800-1914* (London, 1999); 93-112

-----, *Mental Disability in Victorian England: the Earlswood Asylum, 1847-1901* (Oxford, 2001)

-----, 'Delusions of Gender? Lay Identification and Clinical Diagnosis of Insanity in Victorian England', in Digby, Anne and Andrews, Jonathan (eds), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam, 2004); 149-176

Yorston, Graeme and Haw, Camilla, 'Old and Mad in Victorian Oxford: a Study of Patients Aged 60 and Over Admitted to the Warneford and Littlemore Asylums in the Nineteenth Century', *History of Psychiatry*, 16 (2005); 395-421

Young, Robert M., *Mind, Brain, and Adaptation in the Nineteenth Century: Cerebral Localization and its Biological Context from Gall to Ferrier* (New York, 1990)

## Appendix 1: The 1882 Medico-Psychological Association 'Form of Insanity' Classification

- Congenital or Infantile Mental Deficiency
  - With epilepsy
  - Without epilepsy
- Epilepsy Acquired
- General Paralysis of the Insane
- Mania
  - Acute
  - Recurrent
  - Chronic
  - A Potu
  - Puerperal
  - Senile
- Melancholia
  - Acute
  - Chronic
  - Recurrent
  - Puerperal
  - Senile
- Dementia
  - Primary
  - Secondary
  - Senile
  - Organic (ie. from tumors, coarse brain disease, &c.)

'Report of the Thirty-Seventh Annual Meeting of the Medico-Psychological Association', *Journal of Mental Science*, 28 (1882), p. 460

## Appendix : The Format of the Case Books at Hanwell

Figure a. Male case book entry, first page. The female case books are in the same format. William Crick, H11/HLL/B/20/002, p. 252

William Crick admitted March 26<sup>th</sup> 1852 (252)

appears to be about sixty years of age, and is well nourished, but has boils upon his person, is deaf, converses coherently -

May 27<sup>th</sup> is sixty years of age, single, plainly educated, a member of the Church of England, a compositor by trade, was always steady and sober, had good employment and good health - in November 1849 he suddenly, and without any assignable cause, took it into his head that all his relatives were to be murdered, that he should be suspected of the crime, arrested and tried for it; this delusion continuing, medical aid was called in, he was under treatment at home for about six months without benefit. was then sent to Bethlem Hospital from which he was discharged uncured in eighteen months, and then taken to the Surrey asylum and was brought from that here after a residence of six months there - he was never violent nor suicidal but he fancies that he hears his brother calling out to him in a loud voice "save me, save me". Relations sane and healthy - case narrated by his sister in Law at her visit to him today - was Clerk to the Recorder of London for many

Figure b. Male case book entry, second page. William Crick. H11/HLL/B/20/002 (1852), p. 253

253/ William Crick continued from Page 252  
years, resided in the temple, led a  
very secluded life, devoted to reading all  
the time not occupied in his office and  
sat up late at night poring over old  
books and ancient manuscript documents

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Died. 11 Sept 1862



Figure c. Male case book entry. Joseph Forster, H11/HLL/B/20/011 (1872), p. 449.

449  
 Joseph Forster admitted January 1<sup>st</sup> 1872  
 appears to be about seventy years of age, is thin and pale has a graze at the left side of the chest, an eruption on the right elbow, a sore on the sacrum is incoherent and very gregarious weighed nine stone and five pounds

*Med. Clinical Journal HOLL. Page 34 1873.*

June 10. He is in fairly good health but is always complaining of profuse diarrhoea &c. he is cleanly & orderly in dress, does not employ himself in for ever complaining & trying to irritate & annoy those about him by his complaints seems to be about him of being in danger against him, to kill him: and of attempting to poison him

1874  
 Feb: 22<sup>nd</sup>. Continues one of the most discontented irritable old men in the house, abuses all his fellow patients at the least without any provocation, never has anything like others, & can never get attended to etc. He suffers from scrofulous disease of the right elbow.

Oct: 29<sup>th</sup>. No change whatever, declares that everyone in the Asylum wished to murder him.

1875  
 May 31<sup>st</sup>. As irritable as ever; but of late he has not been so strong in health.

Discharged "improved" to the Workhouse.  
 Aug: 11<sup>th</sup>. 1875.  
 Oct: 2<sup>nd</sup>. 1875.



Figure d. Female case book entry, first page. Ann Adams, H11/HLL/B/19/022 (1872), p. 191.

191  
5180  
1872  
July 13  
Melancholia  
weak  
health.

Adams Ann.  
Brentford.

Female - at: 60 - single - domestic servant.  
Church of England - 1<sup>st</sup> attack - duration  
about 3 months - Cause "not known."  
or appears to have committed some  
secret sin. says she has had two  
illegitimate children and abortion  
was created to get rid of them -  
not epileptic. not suicidal nor  
dangerous.

Medical Certificate.  
She has delusion. She says that her head  
is full of beetles which make a peculiar  
noise. Preventing her from sleeping -  
that her food tastes like quicksilver.  
On several occasions she has attempted  
to get out of the window: She will get  
up in the night disturbing other patients  
and saying that some one is calling  
her. She is obstinate and occasionally  
refuses to take her food.

James Jackson.

July 17  
2

Dull, depressed: very apprehensive  
of harm to herself and others: says  
"she has such funny visions in her  
head" - that everything is going wrong  
with her relatives - and that her  
friends are being buried alive. At  
times she hears voices in her head  
like the ticking of watches. Has been  
continued Page 193.

Figure e. Female case book entry, second page. Ann Adams, H11/HLL/B/19/022 (1872), p. 192.

192

Wm. C. Lambert - M.D.  
 44 Slater St., Shoreditch.  
 or "Club Row", Shoreditch.

1872. Statement made by the above.

July 16. A. A. is 60. Single. Domestic Servant. and  
 needlewoman. ~~She~~ Methodist. Can R.W.  
 plain & educated. Born in Hackney.

2<sup>nd</sup> Allack. Duration 10 Months. Class. 3  
 Cause. } Grief at hearing of the death of her sister.  
 Father was Insane. Sister was Insane.  
 Her Father was Insane for many years - & for the  
 last 6 years of his life was confined in an Asylum.  
 Her sister was Insane 2 years. This Patient  
 became Insane about the age of 25. & continued  
 so for ~~18~~ months. Was melancholy & very  
 nervous. Was not sent to an Asylum. Had  
 strange fancies - thought she was pregnant. She  
 again became Insane in September last when  
 she became excessively nervous after hearing of  
 the death of her sister. Became melancholy  
 and low spirited. Thought that she was  
 going to be given into Custody - & was always in  
 dread that something would happen to her.  
 She has enjoyed fair health with the exception  
 of a nervous headache & a burning sensation  
 in the chest.

Not Epileptic. Not Suicidal. Not dangerous.

She had an illegitimate child when she 32  
 years of age. Child Born dead.  
 Parents not related prior to marriage.

Figure f. Male case book entry, first page, top section. Thomas Miller, H11/HLL/B/20/022 (1892), p. 5.

| No.  | NAME.   | ADMITTED.                               | DISEASE.             | RESULT. |
|--|---|---|----------------------|---------|
| 8164   | Miller Thomas   | 4 January 1892                          | Dementia & Paralysis | Death.  |
| Age 69   | Married, Single, or Widowed <u>Widower</u>                                | Previous occupation <u>Warehouseman</u> |                      |         |
| Religion <u>Ch. of England.</u>  | Previous address <u>30 Kenton St. Bloomsbury W.C.</u>                     | Age on first attack <u>66</u>           |                      |         |
| Whether first attack <u>Yes?</u>   |   |   |                      |         |
| When and where under care and treatment <u>Nowhere</u>   |   |   |                      |         |
| Duration of existing attack <u>About 3 years.</u>  | Supposed cause <u>Injury to head.</u>                                     |   |                      |         |
| Whether Epileptic? <u>?</u>  | Suicidal? <u>Yes!</u>   | Dangerous? <u>Yes!</u>                  |                      |         |
| Parish or Union <u>St. Giles. Bloomsbury</u>   | Friend's Address <u>Ernest Miller (Son) 30 Kenton Street. Bloomsbury.</u> |   |                      |         |
| <p>1 Jan. Medical Certificate <u>He has delusions. He says his daughter in law: Mary Ann Miller</u><br/> <u>1892. got him on a barge and tried to drown him in the Thames last week for the</u><br/> <u>sake of his money. He says also that the attendant of the ward, Sydney</u><br/> <u>Austin said on Wednesday last that he was rotten with the bad disorder as</u><br/> <u>a matter of fact he was not admitted to the ward till Wednesday last. Sydney Austin att.</u><br/> <u>of the insane states that he made no statement as to his having the bad disorder. His daughter in law</u><br/> <u>states that he is subject to fits of violence in which he talks about what he used to work &amp; that he then</u><br/> <u>raves and is dangerous but afterwards remembers nothing about the attack. I have seen a certificate</u><br/> <u>signed by E.C. Harris M.D. R.C.P.S.D. dated Dec. 29. 1891 stating that he is of opinion that Thomas Miller is</u><br/> <u>not of sound mind.</u><br/>         History of Case, from whom obtained <u>Ernest Miller (Son) as above. 10.1.92. (Signed) Samuel Lloyd.</u></p> |   |   |                      |         |
| Nationality <u>English.</u>  | Education <u>R. &amp; W.</u>  | Class <u>IV</u>                         |                      |         |
| <p>Family History <u>Father died aged 82. He became demented before death. A nephew of the</u><br/> <u>patient died in Bedlam. Mother died in childhood - no history of consumption - One son</u><br/> <u>of the patient has had rheumatic fever.</u></p>  |   |   |                      |         |



Figure g. Male case book entry, second page, lower section. Thomas Miller, H11/HLL/B/20/022 (1892), p. 5.

of the patient has had rheumatic fever.

Consanguinity None

Personal History Between 40 & 50 years ago his skull was fractured by a crane handle when unloading a ship. Was in Paris for 6 months. Has been a heavy drinker at times - Has had good health - About three years ago he began to take gambler's dislikes to his sons - thought they wanted to stone him &c &c Since then his memory has failed very much. Has had 2 fits one about 6 months ago & another 3 months ago. Has gradually been getting weak on his legs for a long time -

Causes—Predisposing Paternal Heredity & drink      Exciting Secularity.

Condition of Body on admission Body spare, emaciated. Old vaccination marks on left arm. Scars scar on forehead. Large depression on top of fore. Weight 8. 6 8<sup>th</sup>

Result of Medical Examination Head. Pimples on chest and front of right knee. Small sores on each buttock. Deformity of second finger of left hand. There is some contraction of ham string. Both legs appear to be paralyzed. the grasp of the right hand is weaker than that of the left. The face is a little asymmetrical being slightly drawn toward the left. There is no marked alteration in the state

Mental State on admission -

His mind is in a very chaotic condition; he is incoherent & irrational and quite unable to understand about half of what is said to him. Only occasionally answers questions in an intelligent fashion - He is very restless and chatters constantly about himself & his daughter whom he says he has offended. He does not know where he is but imagines he has been put in the dog house "to dry". His speech is a little thick and slurred & in counting he occasionally misses a number.

Perce L. Bail

Figure h. Male case book entry, second page. Thomas Miller, H11/HLL/B/20/022 (1892), p. 5.

Medical Examination (Continued)  
of the reflexes. Irides blue. Pupils equal and react normally. There is slight cloudiness from old keratitis or scleritis in the right cornea. Teeth bad. Palate normal. Tongue clean, steady. Bronchitic rales are audible on both sides of the chest and the cardiac sounds are muffled.

Jan 8. He is drowsy and demented and remains as incoherent as on admission.  
Perry & Bailey

Jan 9. Return. He is demented, incoherent and restless. (Equiv) Dr. Dr. Alexander.

Jan 15. There is no change. Perry & Bailey

Jan 25. He is demented and prostrated.  
H. H. Alderman

July 4. There is no change to note.  
H. H. Alderman

March 10. Paralysis & dementia are gradually becoming more pronounced.  
H. H. Alderman

March 12. He is rapidly going downhill, bed sores are forming, he hardly takes any nourishment. Tonics & stimulants prescribed. R. R. Shethall

March 17. He continues to get worse and more enfeebled.  
R. R. Shethall

March 20. This morning at 10.25 am he died in the presence of Att Coleman.  
cause of death White Softening of Brain.  
duration Indefinite  
R. R. Alexander

Figure i. Female case book entry, first page, top section. Sarah Westcott, H11/HLL/B/19/037 (1892), p. 463.

| 463  |                         | <i>P.M. Refused</i>         |  |                     |                         |
|--|-------------------------|-----------------------------|--|---------------------|-------------------------|
| NO   | NAME.                   | ADMITTED.                   | DISEASE.   | RESULT              |                         |
| 9022   | Westcott Sarah          | 25 May 1892                 | Senile Melancholia   | Death               |                         |
| Age  | 64                      | Married, Single, or Widowed | Widow  | Previous occupation | Miscellaneous workhouse |
| Previous Address   | Hackney Union Infirmary | Whether first attack        | No. 2  | Name of Husband     | William Westcott        |
| Religious persuasion   | Congregationalist       | Duration of existing attack | 4 weeks  | Occupation of       | Silver Plate            |
| Age on first attack  | 30                      | Supposed Cause              | Influenza  | How discharged      |                         |
| When and where under care and treatment  | Nowhere                 | Whether Epileptic?          | No   | Suicidal?           | Yes                     |
| Parish or Union  | Hackney                 | Friend's Address            | William Edward Westcott Esq.,<br>41 St. Eastern Rd.,<br>Stratford E. |                     |                         |
| Date of Reception Order  | 25 May 1892             | Dangerous?                  | No   |                     |                         |
| Person signing Reception Order   | J. McCall               | Medical Certificate         | 25 May 1892  |                     |                         |
| <p>She is depressed, melancholic, suicidal having attempted to strangle herself. She says she is so much wrecked that she is not worthy of being seen by anyone. She imagines she is going to die &amp; that her soul is lost.</p> <p>(Signed) John Impey Gordon</p> |                         |                             |  |                     |                         |

Figure j. Female case book entry, first page, lower section. Sarah Westcott, H11/HLL/B/19/037 (1892), p. 463.

History of Case, from whom obtained *William S. Westcott - Rev. apabere.*  
 Date *29. May 1892.* Nationality *English*  
 Is the *5* of a Family of *8* Number now living *4.*  
 Number of children *5* Living *5*  
 Is the disease hereditary? *Yes! Both sides* Relatives affected *1 Pat. Cousin + 2 nephews.* Age of youngest *28*  
 Family History of Nervous Disorders *Mother was paralysed + 2 sisters are paralysed.* Education *Rd.*  
 Previous attacks, if any *Yes.* Duration of existing attack *About 3 months.* Class *III*  
 Whether Suicidal, and in what manner *Yes!* Threatened *—* Attempted *To strangle herself.*  
 Whether Epileptic? *No!* Dangerous? *No!*  
 Disposition and habits in health *Blameful - Good tempered - Very Rily given* If temperate *Yes!*  
 Are the habits cleanly? *No!* Has there been refusal of food? *No* Sleeps badly  
 If destructive, in what manner *No.* State of catamenia  
 Previous bodily health *Always nervous -*  
 Habits, &c., of Parents *Father died of old age. Both temperate* If Parents related prior to Marriage *No!*  
 Family History of Phthisis *No!* Family History of Intemperance *No!*  
 Supposed cause—a Predisposing *Previous attack + Heredity (Both sides)* Exciting *Serious Influenza.*  
 Development Temperament Weight *7* st. *10* lbs.  
 Condition—Digestive System Pulse  
 „ Circulatory „  
 „ Respiratory „  
 „ Genito Urinary System  
 „ Speech. Gait.  
 „ Special senses  
 Mental state and Bodily Health and Condition *on admission* Date  
*She is extremely depressed - melancholy. Says that she is quite lost & tried to strangle herself because she was so miserable.*  
 Body spare, nourished. Vaccination marks left arm. Abscess on back. Varicella on both legs. Joints of feet toes enlarged. Left foot too much swollen. Also finger of left hand. Pupils equal. Moderately dilated. Was many false teeth on admission. Tongue protruded straight. Chord sound. normal.  
 W. J. Thomas  
 1892/5/29

Figure k. Female case book entry, second page, top section. Sarah Westcott, H11/HLL/B/19/037 (1892), p. 463.

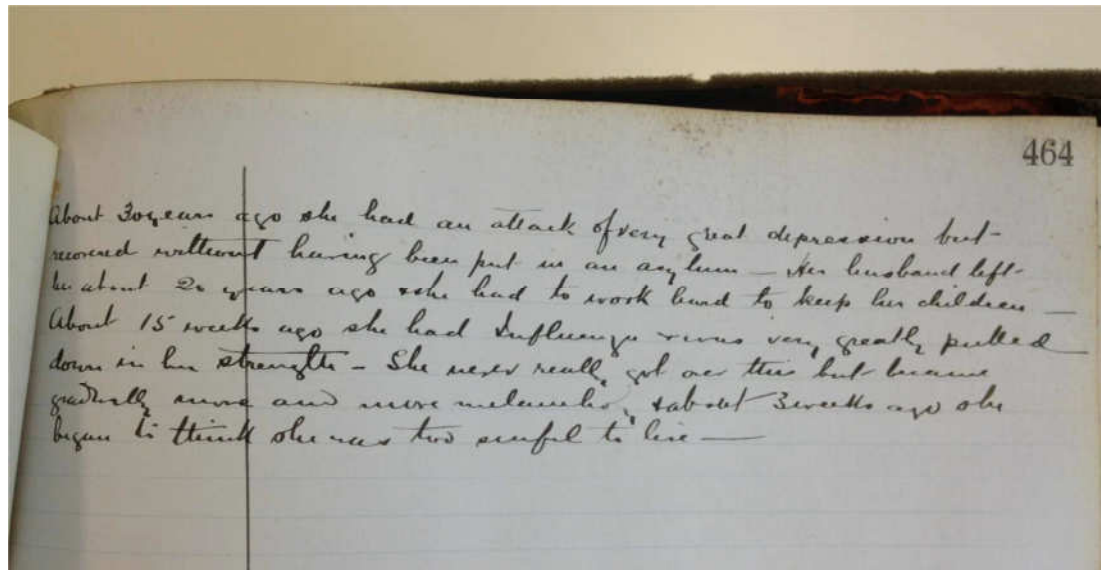




Figure 1. Female case book entry, second page, lower section. Sarah Westcott, H11/HLL/B/19/037 (1892), p. 463.

1892  
 Mental Condition, &c., on admission.  
 May 15. On admission she was sent to ward 2  
 & placed under continuous supervision.  
 R. J. Thomas  
 May 27. She remains very greatly depressed  
 and says she is too sinful to live -  
 Perry J. Bailly  
 May 27. Return "I say she is miserable  
 too sinful to live & actively  
 suicidal". (Signed) R. R. Alexander  
 June 5. So as melancholy as ever and does  
 not take her food well. Perry J. Bailly  
 June 12. She remains very melancholy but  
 is now able to get up. Perry J. Bailly  
 June 23. No change. Perry J. Bailly  
 July 12. So intensely melancholy and  
 imagines her body is dead. M. Bailly  
 Aug. 5. She is restless at night, refuses  
 her food & has the delusion that  
 her body is a mass of corruption  
 & her breath poisonous to the  
 other patients in the ward. So losing  
 flesh. Perry J. Bailly  
 Aug. 21. She thinks she is too wicked to live &  
 asks to be sent to her punishment  
 takes food very badly. Perry J. Bailly  
 Nov. 27. She is now very low. She never  
 speaks and refuses her food. She is  
 losing flesh rapidly and is now  
 very thin. Perry J. Bailly  
 1893. Feb. 21. She is profoundly melancholy  
 & never speaks. Perry J. Bailly  
 May 3. Return. "S. Mel. She is most depressed;  
 never speaks; has to be fed". R. R. Alexander  
 June 16. 93. The patient  
 died at 7.00 p.m. yesterday  
 Cause of Death - Melancholic Exhaustion  
 (one year)  
 R. R. Alexander.

Figure m. Female case book entry, first page. *Jemima Burns*, H11/HLL/B/19/062 (1911), p. 142. The male case books are in the same format.

Name *Burns Jemima*, Aged *77*, Reg. No. *14118*, Admitted *6 Sept.* *1911*.

Reception Order signed by *E. Lee Sinclair J. P.* Dated *5 Sept.* *1911*.

Sex and Age *Female 77* Civil State *Widow* Occupation *Old age pensioner* Religion *Presby.*

First attack *70* Age on first attack *77* When and where previously under treatment *Admitted to hospital 1890 previously under care & treatment.*

Duration of present attack *Some weeks* Supposed cause *Not known* Treatment *None*

Cap of STATEMENT OF PARTICULARS

Suicidal *No* Dangerous to others and how *No* Epileptic *No*

Any near relative afflicted with Insanity *No* Union chargeable to *S<sup>r</sup> Paviour*

Previous Place of Abode *61 Stubbington Street* Name and Address of Person to whom Notice of Death to be sent *Daughter*

Names and Addresses of one or more relatives of the Patient *Daughter Alice Day, 17 Chiseldon St<sup>r</sup> Somers Town N.W.*

MEDICAL CERTIFICATE

Signed by *Andrew Brodie M.D.* *5<sup>th</sup> Sept 1911*

(a) Facts indicating insanity observed by myself at the time of examination, viz. — *She denies the story about men wanting to get into bed with her, but says she sees them come into the house for other people.*

(b) Facts communicated by others, viz. — *Charge Nurse Kate Stewart Hunt told me she has the delusion that men come into the house at night & try to get into bed with her, talks to imaginary people. These delusions are stronger at times than others.*

HISTORY. Whence obtained *Daughter Sept 26 1911*

PERSONAL:—Patient is the *1<sup>st</sup>* of a family of *5* of whom *1* are alive. Born at full time. Labour protracted or instrumental. Cut first tooth when aged *months*. Commenced to walk at *months*. Catamenia first appeared when aged *years*, regularity *ceased* ago. Was *to learn when a child*. Education *reached standard at school when aged*. Educated at *Weak minded since a child*. Been able to earn own living up to *7 years ago - London*. Convulsions during infancy *Any fits since, and age at first one 1 1/2 18-19 years*. Frequency *date of last one* Any injury to head *h<sup>2</sup>* Suffered from Somnambulism, Rickets, Chorea. Rheumatic Fever, Scarlet Fever, Giddiness, Headaches, Asthma, Influenza or Gout (*state age and particulars*) *Shingles twice 1890 & 1900*. If contracted Syphilis or Gonorrhoea when *duration of treatment* Any other venereal disease *none* Other illnesses, with dates *Consumption*. Hospital or medical attendant *any tendency to*. If married, when *50 years ago* History of pregnancies and children *4 children 2 are alive, 0 miscarriage*. Habits *Sexual excess*. Intemperance in drink, nature, amount and duration *no*. Patient's disposition *good*. Criminal history *no*. First mental symptoms noticed *1890*. their nature and subsequent events up to admission *felt she was being watched by 5 Paviour & her daughter*. Suicidal attempts *none*. Violent to others *none*. Insomnia *no*. Cause ascribed by friends for present illness *Where was patient born* *Widow's Hill, Suffolk*. Places of abode, abroad or in this Country *no*.

FAMILY:—Including Parents, Grandparents, Brothers and Sisters, Uncles and Aunts, Cousins, Nephews and Nieces (stating if on maternal or paternal side).

Ages of parents at time of their marriage—father *years*, mother *years*; at all related to each other *cause of and age at death of any of the above* *X. 1890. 1900. 1900. 1900.*

Cases of Alcoholic Intemperance *none*

Cases of mental Break-down *none*

Cases of Epilepsy or Paralysis *none*

Cases of Consumption *Brother died of it.*

OTHER FACTS:—*Paviour has always been good. Mentation always good. Never known to talk to herself & always second most sensible. Was living with Paviour when he came to be admitted into the asylum.*

Figure n. Female case book entry, second page. Jemima Burns, H11/HLL/B/19/062 (1911), p. 142.

| Transferred from   |  | In Ward                                |                                      |
|--|--|--|--------------------------------------|
| <b>CONDITION ON ADMISSION.</b>   |  |  |                                      |
| <i>An entry, positive or negative, is to be made opposite each heading.</i>  |  |  |                                      |
| <b>PHYSICAL:</b> General bodily condition  | Poor   | Nourishment                            | Feeble                               |
| Deformities  |  | Height                                 | ft. in. Weight                       |
| Scars, Bruises, other signs of recent or old injury, Pigmentations, Eruptions, Joints                              |  |  | St. lbs. Temp. 97.6. °F.             |
| Sweat  |  |  |                                      |
| Right Tibia fractured about Aug. 5 <sup>th</sup> . Plaster applied about Aug. 30 <sup>th</sup> , last united then. |  |  |                                      |
| Old vac. marks left arm.   |  |  |                                      |
| CRANIUM—General shape  | Normal   | horiz. circumf.                        | 3 centim. above root of nose         |
| level $\times 100 \div$ ant. post. diam. at same level   |  | c.m. Cranial Index                     | — (greatest transverse diam. at this |
| distance between their inner angles  |  | FACE—Any special type                  |                                      |
| Nose   |  | Symmetry                               |                                      |
| Mouth (scars)  |  | Forehead                               |                                      |
| Complexion   | Healthy  | Palmar and expression lines            |                                      |
| Palate (with arrangement and shape of Teeth)   | Edentulous   | Expression                             |                                      |
| Ear  |  | Craniocfacial angle                    |                                      |
| Darwin's Tub.  |  | EARS—Size and symmetry                 | Normal                               |
| Ant. Helix   |  | Lobules, free adherent, size           |                                      |
| SKIN—  | Pale   | on face                                | No                                   |
| THYROID—   | Normal   | elsewhere                              |                                      |
| NERVOUS SYSTEM—Motor impairment  | Yes  | Speech                                 | Normal                               |
| Tremors  | Seizure  | Co-ordination                          | Normal                               |
| Station  | ?  | Gait                                   | ?                                    |
| Musculature  | Very feeble  | Tactile sensation                      | Normal                               |
| Deglutition  | Normal   | Knee Jerks                             | Normal                               |
| Trophic lesions, wastings, &c.   | Seizure  | Plantar reflex                         | Yes                                  |
| Eyes   | Slight corneal opacity   | Sight                                  | Feeble                               |
| Exophthalmos   | No   | Nystagmus                              | No                                   |
| R. L. Consensual R. L.   |  | Pupils—size                            | Normal                               |
| VASCULAR SYSTEM—Edema  | No   | Hearing                                | Normal                               |
| Injection of Cutaneous capillaries   | No   | Anæmia                                 | No                                   |
| Pulse  | 84 per min.  | Cyanosis                               | No                                   |
| HEART—Apex-beat  | Outside nipple line by 1 finger breadth                              | Vessel-wall, Radial                    | Arteriosclerotic                     |
| Percussion and Auscult.  | Sound clear, occasional systolic murmur, there is cardiac dilatation | Elsewhere                              |                                      |
| RESPIRATORY SYSTEM—Shape of Chest  | Normal   | Respirations                           | 16 per min.                          |
|  |  | Cough                                  | No                                   |
|  |  | Exam. of Lungs                         | Normal                               |
| ALIMENTARY SYSTEM—Teeth  | None   | Gums                                   | Normal                               |
| Breath   | Liver  | Tongue                                 |                                      |
| Abdomen  |  | Hernia (state whether reducible)       | No                                   |
| GENERATIVE SYSTEM—Menstruation   | Current  | Evidence of pregnancy—Past             |                                      |
| Present  | Breasts  | Discharges, &c.                        |                                      |
| Scars in groin   |  | Patient's statement as to pregnancies— | 5                                    |
| No. of children alive  | 2  | Miscarriages                           | and when                             |
| Still-born children  |  |  |                                      |
| SYPHILIS—(congenital) physical evidence of   |  |  |                                      |
| (acquired) history of  |  |  |                                      |
| URINE—Amt. in 24 hrs.  | Sp. Gr.  | React.                                 | Album.                               |
|  |  |  | Sugar                                |
|  |  |  | Deposit                              |
| <b>MENTAL STATE:—(As far as possible under headings stated on Case Paper)</b>                                      |  |  |                                      |
| She sees men come into the ward & they try to get to bed with her.   |  |  |                                      |
| She is for an old lady fairly sensible, she is a little confused, partly accounted for by deafness.                |  |  |                                      |
| She is inclined to mistake identities, says she saw me last Monday.  |  |  |                                      |
| She is said to get weakly restless & terrified by hallucinations.  |  |  |                                      |



Figure o. Female case book entry, third page. Jemima Burns, H11/HLL/B/19/062 (1911), p. 142.

| Name <i>Burns, Jemima</i>  |   |
|--|---|
| <p><i>History Daughter</i><br/> <i>1st of 5 1 alive</i><br/> <i>Reminded up to 5 years ago.</i><br/> <i>One fit 12 years ago, lasted 20 minutes</i><br/> <i>Strangulated hernia 14 years ago.</i><br/> <i>Malaria 30 years ago, 4 children, 2 now alive 0 misses.</i><br/> <i>No Mucidity.</i><br/> <i>About 1 month ago fell &amp; broke her leg, now taken to St. Pancras Infirmary.</i><br/> <i>Daughter now suffers any mental disorder.</i><br/> <i>Sanity.</i></p> |   |
| PROGRESS OF CASE.  |   |
| Date.  | Date.   |
| 1911   | 1912  |
| Sept 7-<br>3-  | Feb 16-<br>2-   |
| Rattin restless, clean in her habits. Taken her food. Confined to bed with her fractured leg, which is still up in plaster.  | She is restless, & always in a state of doubt about her leg. She is frequently in bed for it, & it occasionally becomes oedematous.   |
| 12-  | May 30-<br>Aug 8-<br>2-   |
| Return <i>✓</i> She is laboring under Severe Dementia. She is childish and simple minded, suspicious, & is markedly restless & terrified by hallucinations at night. She is in feeble health, scind and decupit. She was admitted with her leg in Plaster of Paris, the report with her showing that the right tibia was fractured on August 5 <sup>th</sup> , & a plaster of Paris splint was applied on August 30 <sup>th</sup> when the bone had united.              | No mental change.<br>Return <i>+</i> Severe Dementia.<br>She is simple & restless, bursts into tears when I speak to her & is depressed.<br>She is in feeble health.  |
| Sept 21-<br>3-   | Nov 17-<br>2-   |
| Scind, simple & demented. Gives no trouble. Confined to bed on account of fractured leg.   | She is quiet & demented, does needlework, is up daily & gives no trouble.   |
| 26-<br>3-  | 1913  |
| Splint taken off. Massage ordered 10 times twice daily. There is much bruising over the calf.  | Feb 27-<br>2-   |
| Oct 14-  | May 31-<br>July 17-<br>2-   |
| Moved to 2. Mentally she is scind & simple, frequently bursts into tears.  | Shows no mental change.<br>Yesterday morning forearm felt off the stone & hurt her side.<br>On exam. Capitis was felt as a rib on 2 <sup>d</sup> side. Strapping has been applied. She complains of pain on breathing. However her condition is quite good.   |
| 27-<br>2-  | Aug 14-<br>2-   |
| She is scind & shows no improvement mentally.  | Return <i>+</i> Severe Dementia.<br>She is simple, childish & restless, does a little needlework, but is much demented & her memory is very poor.<br>She is in fair health for her age & was just recovered from a fractured rib obtained by slipping & falling against her bed in the dormitory while getting up in the morning. |
| Nov 20-<br>2-  |   |
| She is scind & depressed, restless & childish, bursts into tears about nothing.  |   |
| She is now up & about & her leg is much more useful to her.  |   |

Figure p. Female case book entry, admissions statistics insert. Jemima Burns, H11/HLL/B/19/062 (1911), p. 142.

PHYSICAL: General bodily condition *Poor* Nourishment *Feeble* Height ft. in. *5* Weight *125* lbs. *Starkley*

ADMISSION STATISTICS (as tabulated December 31st, year of Admission).

Name and Occupation of Husband *William Burns* *Hotel Porter*

| Attack.    | Ever previously certified. | If not 1st Attack length of time since recovery. | Age.                  |                                    |                | Duration of Present Attack prior to Admission. | Deemed suicidal on Admission. | Alcoholism. |            | Syphilis.  | Etiological Factors—Principal (Exciting) <i>Senility</i><br>Contrib. and Assocd. |
|------------|----------------------------|--|-----------------------|------------------------------------|----------------|--|-------------------------------|-------------|------------|------------|--|
|            |                            |  | On Present Admission. | At Commencement of Present Attack. | On 1st Attack. |  |                               | Personal.   | Fam. Hist. |            |  |
| <i>no.</i> | <i>no.</i>                 |  | <i>78.</i>            | <i>78</i>                          | <i>78.</i>     | <i>4 weeks</i>                                 | <i>no.</i>                    | <i>no.</i>  | <i>no.</i> | <i>no.</i> |  |